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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/17/2026 |
| NAME OF PROVIDER OR SUPPLIER LA Bella of Woodstock | | STREET ADDRESS, CITY, STATE, ZIP CODE 309 McHenry Avenue Woodstock, IL 60098 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on interview and record review the facility failed to ensure a resident who receives continuous oxygen was provided oxygen services during transportation to an outpatient procedure. This applies to 1 of 3 residents (R3) reviewed for oxygen services in the sample of 9. The findings include: R3's Facesheet dated 2/11/26 shows R3 has diagnoses including, but not limited to: chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, and dementia. On 2/11/26 at 10:32 AM, R3 was seen lying in bed with a nasal canula adorned and the oxygen concentrator supplying oxygen at a rate of 2 liters per minute. R3's Health Status Note from 1/23/26 at 2:49 PM, by V11 (Nurse Practitioner) shows R3 receives chronic 2L (liters) [oxygen] N/C (nasal canula) for COPD. On 2/17/26 at 8:17 AM, V13 (Receptionist/Transportation Coordinator) called R3's insurance company to confirm the information provided at the time R3's transportation services were requested. On the phone, V17 (Insurance Representative) confirmed that V13 had requested R3's transportation included services for 2 liters of oxygen. On 2/17/26 at 9:01 AM, V15 (Transportation Dispatcher/Operations Manager) confirmed the reservation for R3's transportation was completed through R3's insurance. V15 said the level of services requested to transport R3 was for a non-emergency medical stretcher ride. V15 confirmed this type of transportation does not provide oxygen on the vehicle, but V15 said the facility could provide oxygen for the resident and the stretcher could hold the travel oxygen tank. On 2/17/26 at 11:30 AM, V16 (Transportation Driver) said when V16 arrived at the facility, R3 was lying in bed with no oxygen adorned. V16 transferred R3 onto a stretcher and loaded R3 into the transportation van. V16 said staff on site did not indicate R3 required oxygen nor did staff provide R3 with an oxygen canister for the trip. V16 also said at no point during the trip did R3 experience any signs or symptoms of shortness of breath or distress. On 2/17/26 at 11:54 AM, V14 (Manager of Care Coordinator) said it was reported to V14 via direct message from the care team that R3 arrived to the local hospital on 1/21/26 for an outpatient surgery with oxygen saturation levels below 90 percent. V14 said the first recorded oxygen saturation level was at 91% at 12:11 PM after being provided oxygen via a nasal canula. On 2/11/26 at 1:27 PM, V11 said R3 has a history of COPD and chronic hypoxic respiratory failure. V11 would prefer that R3 is transferred to a hospital appointment with oxygen.</p> | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 145222 | Facility ID: 145222 If continuation sheet Page 1 of 1 |