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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Woodstock	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free of verbal and mental abuse for 2 of 5 residents (R1 and R2) reviewed for abuse in the sample of 7. The findings include:1. On 3/30/26 at 9:20 AM, R1 said that last week a black male Certified Nursing Assistant (CNA) came into the room around 5:55 AM to provide care to R2. R1 said that the CNA left the room door open. R1 said that he sat up in bed and told the CNA that the door needed to be closed and the CNA responded that he does not close the doors when he is providing care because he is working. R1 said that he then said to the CNA, I could make a complaint to the state and the CNA responded, Do what you have to do mother f***er. R1 said that he then got up from bed, closed the door and went to the bathroom. R1 said that morning, he told V3 (Activity Director) what had happened. On 3/30/26 at 2:30 PM, R2 said that last week he was receiving incontinence care from a CNA when R1 and the CNA started to argue about the door being closed. R2 said that while the CNA was wiping his perineal area, the CNA called R1 a mother f***er. R2 said that then R1 got up and closed the door and went to the bathroom. R2 said that when R1 was in the bathroom, the CNA kept talking about him and referring to him as a mother f***er multiple times. R2 said that the word was used towards R1.On 3/30/26 at 11:01 AM, V3 (Activity Director) said that last week, R1 came up to her and was very anxious. R1 told her that an African American male CNA was using not kind words with him. V3 said that she does not recall exactly what R1 told her, but it was something about he wanted to door closed and the CNA was rude and wanted him reported. V3 then went and immediately told V1 (Administrator).On 3/30/26 at 12:17 PM, V1 (Administrator) said that when she came in on 3/26/26, staff had reported to her that R1 had an issue with a night CNA. V1 said that she immediately went and spoke to R1. V1 said that when she asked R1 what had happened, he said that a CNA told him to F*** off. V1 said that she asked him who it was, and he said it was a black male CNA. V1 said that she interviewed the black male CNAs that were currently working and none of them had any interactions with R1. V2 said that she then looked at the scheduled and called V10 (black male agency CNA) that had worked the night shift. V1 said that when she spoke to V10, he said that he was providing care to R2 and R1 was being rude and disrespectful. V1 said that V10 did admit to swearing in the room. V1 said that V10 said that he had crocs on and hit his foot on the bed and yelled out using profanity. V1 said stated, He yelled out the F word or something like that. R1's Minimum Data Set assessment dated [DATE] shows that his cognition is intact. R1's Care Plan does not document that he has a history of making false statements of abuse. On 3/31/26 at 2:25 PM, V2 (Director of Nursing) said that R1 does not have a history of making false statements since she has worked there (since October,2025). On 3/30/26 at 3:45 PM, V13 (CNA Supervisor) said that R1 has not made any false statements that he is aware of in the past. On 3/30/26 at 12:50 PM, V10 had two numbers listed on a witness statement. Both numbers were called and both numbers were disconnected. The undated Witness Statement shows, Asked if he remembers an incident with resident in [R1's room], [V10] indicated, yes. [V10] then stated, I was going into the room providing care to roommate and [R1] had been making rude comments aggressive towards me the entire time I was in his room. I did not engage with him as I was taking care of the (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER LA Bella of Woodstock		STREET ADDRESS, CITY, STATE, ZIP CODE 309 McHenry Avenue Woodstock, IL 60098	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roommate. While I was providing care I hit my foot and it hurt. I never swear at any residents I was wrong in swearing in the room.On 3/30/26 at 2:30 PM, R2's bed was observed. R2's bed had wheels at the head of the bed and the foot of the bed. R2 verified that when V10 was swearing, he was in the middle part of the bed providing perineal care to R2. 2. On 3/30/26 at 9:40 AM, R2 said that last week some time, the day after hospice had just came to give him a bath, V7 (CNA) and V8 (CNA) came into his room to clean him and get him up. R2 said that when V7 came into the room, V7 stated, You stink. R2 said that he told V7 that he should not stink because the hospice aid was just in the day before and gave him a bath. R2 said that V7 proceeded to say, Everyone in this place hates taking care of you. R2 said that it made him pretty upset and feel bad about himself. R2 said that R1 was in the room when it happened. On 3/30/26 at 2:30 PM, R1 said that he was laying in bed when V7 and V8 entered the room. R1 said that as soon as V7 came into the room, she told R1 that he stinks. R1 said that then R2 responded that he should not stink because he just got a bath the day prior. R1 said that then V7 said, No one want to take care of you, you are always complaining, not even hospice. R1 said that he thought that those comments were very rude. R2's Minimum Data Set assessment dated [DATE] shows that his cognition is intact. R2's Care Plan does not document a history of making false abuse allegations. On 3/31/26 at 2:25 PM, V2 (Director of Nursing) said that R2 does not have a history of making false statements since she has worked there (since October 2025). The facility's Abuse Policy shows, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to ensure a resident received timely medical treatment of a fractured leg that was sustained from a fall for 1 of 3 residents (R4) reviewed for quality of care in the sample of 7. The findings include:R4's Face Sheet shows diagnoses of end stage renal disease and dependance on dialysis, acquired absence of right leg-below the knee, osteoporosis, muscle weakness, lack of coordination, abnormal posture, anxiety, dementia and Alzheimer's disease.R4's Hospital admission History and Physical dated 3/6/26 shows, Patient reportedly had a fall at the facility yesterday, however it is unclear if any evaluation was performed afterwards. He was sent for his scheduled dialysis session this morning where he appeared agitated and pointed to his left leg-appeared uncomfortable. Dialysis staff directed patient to the ER (emergency room) for further evaluation. XR (Xray) left femur with minimally displaced fracture of the distal femoral metadiaphysis.Patient to be kept n.p.o (nothing by mouth) in anticipation of internal fixation procedure per ortho tomorrow. R4's Hospital Notes show that he had an intramedullary nailing performed on 3/7/26.R4's Fall Incident Note shows that he had a fall in his room on 3/4/26 at 7:25 PM. The Incident Report shows, While resident was yelling in his room. This RN [Registered Nurse] gone to check, found sitting on the floor between his recliner and the furniture next to the heater.Resident stated he was sitting in the recliner in front of the heater sleeping and slid down.On 3/31/26 at 11:45 AM, V16, (RN) said that she was at the nurse's station when she heard R4 yelling. V16 said that she entered the room and saw R4 on the floor next to his recliner (high back wheelchair). V16 said that she called for the CNA (Certified Nursing Assistant) and they got him back to bed using a gait belt. V16 said that when they got him back to bed, she did a full assessment on him (R4). V16 said that she did range of motion on R4's extremities. V16 said that R4 was not able to move his left leg very much but that was his baseline, and he was not complaining of any pain. V16 said that she did give R4 some tramadol (pain medication) around 11:00 PM because he was agitated. V16 said that she does not remember what he was doing but she sometimes gives him tramadol and melatonin to help him sleep. V16 said that she is not sure why she marked that R4 was having pain on the medication administration record. On 3/31/26 at 12:35 PM, V18, (CNA) said that she heard the nurse yell for help and entered the room and saw R4 on the floor next to his wheelchair. V18 said that R4 was transferred back to bed using a gait belt. V18 said that V16 did an assessment when he was in bed and when she moved his left leg, he said Oww and started cussing. V18 said that she did incontinence care after the fall and R4 was screaming at her to leave him alone but that was normal for him.On 3/31/26 at 3:08 PM, V21 (RN) said that she was the night nurse for R4 on 3/4/26. V21 said that when she got report from V16, V16 said that she gave R4 a tramadol (pain medication) around 11:00 PM because he was yelling in pain. V21 said that during her shift, he was sleeping and had no complaints. V21 said that the next morning when she was on her way out, V7 (CNA) came up to her and V22 (RN) and said that R4 was having leg pain. V21 said that she did tell V7 that he did have a fall the prior day but then she left since her shift had ended.On 3/31/26 at 11:11 AM, V7 (CNA) said that she was R4's CNA on 3/5/26 for day shift. V7 said that she entered the room to get him cleaned up and up in his chair as usual. V7 said that when she went to put his pants on, he started screaming that his left leg hurt and that he fell yesterday. V7 said that she immediately went to the nurse to let her know. V7 said that V21 and V22 were both present when she told them that R4 was yelling that his left leg hurts and is painful when moved. V7 said that they told her that he did have a fall the day prior and they were taking care of it. V7 said that she then went back into his room and made him comfortable and did not get him out of bed. On 3/31/26 at 11:25 AM, V22 said that she was the nurse for R4 on 3/5/26 during day shift. V22 said that R4 has behaviors of screaming out and on 3/5/26, he wasn't screaming out anything more than normal. V22 said that she does not remember V7 talking to her about him having pain. On 3/31/26 at 1:03 PM, V20 (CNA) said that she took care of R4 on 3/5/26 during PM shift and night shift. V20 said that R4 was in bed when she started her shift. V20 said that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not sure why he was in bed because he is usually up. V20 said that when she provided incontinence care to R4, he was saying, don't touch me, I'm in pain, I'm in pain. V20 said that she asked him where and he said his body. V20 said that she did not report it to the nurse because it was normal for him to be yelling.R4's Progress Notes dated 3/6/26 at 12:11 PM shows, Received call from dialysis center. Per center, sending patient to ER d/t (due to) complaints of pain while at center.R4's March Medication Administration Record shows that between 3/4/26 and 3/6/26 he received one dose of as needed tramadol on 3/4/26 at 11:00 PM for a pain at a level 3. R4's Progress notes between 3/4/26 and 3/6/26 do not show that R4's complaints of left leg pain was assessed nor that the physician was notified of any change in condition.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review that facility failed to have fall prevention interventions in place for a resident at risk for fall. This applies to 1 of 3 residents (R4) reviewed for safety and supervision in the sample of 7. This failure resulted in R1 slipping out of his high back wheelchair and sustaining a left femur fracture.The findings include:R4's Face Sheet shows diagnoses of end stage renal disease and dependance on dialysis, acquired absence of right leg-below the knee, osteoporosis, muscle weakness, lack of coordination, abnormal posture, anxiety, dementia and Alzheimer's disease.R4's Hospital admission History and Physical dated 3/6/26 shows, Patient reportedly had a fall at the facility yesterday, however it is unclear if any evaluation was performed afterwards. He was sent for his scheduled dialysis session this morning where he appeared agitated and pointed to his left leg-appeared uncomfortable. Dialysis staff directed patient to the ER for further evaluation. XR (Xray) left femur with minimally displaced fracture of the distal femoral metadiaphysis.Patient to be kept n.p.o (nothing by mouth) in anticipation of internal fixation procedure per ortho tomorrow. R4's Hospital Notes show that he had an intramedullary nailing performed on 3/7/26.R4's Fall Incident Note shows that he had a fall in his room on 3/4/26 at 7:25 PM. The Incident Report shows, While resident was yelling in his room. This RN [Registered Nurse] gone to check, found sitting on the floor between his recliner and the furniture next to the heater. Resident stated he was sitting in the recliner in front of the heater sleeping and slid down.R4's Fall Care Plan shows that R4 is at high risk for falls. Fall Prevention Interventions that were in place prior to 3/4/26 include: Remind patient of good posture in wheelchair. If patient slouching or fatigued redirect patient to lay down, staff are to ensure resident is properly seated in his wheelchair, place non-skid mat in wheelchair to assist in preventing patient from sliding out of chair, dycem non-slip pad replaced.On 3/31/26 at 11:45 AM, V16, (Registered Nurse-RN) said that she was at the nurse's station when she heard R4 yelling. V16 said that she entered the room and saw R4 on the floor next to his recliner (high back wheelchair). V16 said that she called for the CNA (Certified Nursing Assistant) and they got him back to bed using a gait belt. V16 said that typically R4 goes back to bed after dinner time. V16 said that she asked R4 what happened, and he told her that he just slid out of his wheelchair. V16 said she noticed that his reclining wheelchair was in the upright position and not reclined how it usually is when he is in it. V16 said that she also noticed that he did not have a non-slip pad on his chair. V16 said that she felt that due to the chair not being reclined and being off-balance due to his amputated right leg, that caused him to slide off of the wheelchair. V16 stated, Maybe that day, the girl (CNA) didn't know all the things.On 3/31/26 at 12:35 PM, V18, (CNA) said that she has worked at the facility for about 3 months. V18 said that on the day of R4's fall, she had brought him to his room after dinner. V18 said that she did not get him up into his chair prior to dinner because he was already up. V18 said that he had just returned from dialysis before dinner, so she is assuming that the transport people put him in his chair. V18 said that typically when he returns from dialysis, the transport people use a sheet to transfer his either into bed or into his chair. V18 said that R4 typically goes back to bed around 7:30 PM. V18 said that she heard the nurse yell for help and entered the room and saw R4 on the floor next to his wheelchair. On 3/31/26 at 1:21 PM, V19 (CNA) said that she routinely took care of R4. V19 said that R4 would typically come back to the facility around 4:30-5:00 PM from dialysis and the transport people would put him into bed. V19 said that he would be transferred to his high back wheelchair before dinner using a mechanical lift. V19 said that after dinner, R4 would be placed in the TV room to watch TV and allow for his food to digest. V19 said that after dinner, his wheelchair should be reclined slightly to prevent him from falling out. V19 said that they also put him in the TV room so they could watch to make sure that he does not fall asleep in his chair and fall out. On 3/31/26 at 2:25 PM, V2 (Director of Nursing) said that she investigated R4's 3/4/26 fall. V2 said that she did not speak to V18 about the incident and she does not recall if she spoke to V16 about it. V2 said that she (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	does not know if R4 had a non-slip pad in his wheelchair or not prior to his fall. V2 said that the root cause of the fall was that he slid out of his wheelchair. V2 said that R4 has slid out of his wheelchair in the past. V2 said that she thinks that she added the intervention of dycem (non-slip pad) to his care plan to prevent further falls. V2 said that if R4's Care Plan shows that he should have dycem on his wheelchair as a fall prevention intervention, he should have had dycem on his wheelchair. V2 said that R4's left leg fracture is from his fall on 3/4/26 and not from anything else. The facility's Fall Prevention Program shows, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.