

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 04/16/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent resident to resident abuse for 4 of 4 residents (R1,R2,R3,R4) reviewed for abuse in the sample of 4. Findings include:1. On 04/16/2026 R1's at 9:30AM, R1 was lying in his bed in his room. At 1:05PM, R2 was lying in his bed in his room. On 04/16/2026 at 9:30AM, R1 said, on 03/28/2026 I was sitting in my wheelchair in the hallway when R2 said, get out of my way, I am going to kick your ass. He threatened me and there was a scuffle. We threw some punches; I was hit with a coffee cup. A couple days later (03/30/2026) I went down to a community area to sit with my buddies. V3 RN-Registered Nurse started making a fuss. R2 heard V3. R2 came out of his room and started another fight with me. R2 was in his room; R2 came out when the nurse started a big commotion asking me to leave.On 04/16/2026 at 10:09AM, V1 Administrator said, R2 pushed R1's wheelchair with his foot. R2 was attempting to move R1's wheelchair out of the way. R2 had an empty plastic cup. R1 and R2's arms were swinging, maybe the cup touched R1. R1 said R2 kicked him. R2 said, he pushed R1 with his foot. R2 wanted to get through an opening, R1 said, you can't tell me what to do.On 04/16/2026 at 1:05PM, R2 said, I have had an altercation a couple of weekends ago (03/28/2026). There is a lot of traffic at the nurse's station. I ended up shoving R1. The police told me; I should not do that. R1 started swearing, came at me, spit at me. I had a coffee cup in my hand; I hit him in the face with it.On 04/16/2026 at 3:58PM, V3 RN said, on 03/30/2026 R1 and R2 were yelling and screaming at each other. I assessed R1; R1 claimed to be assaulted. R1's personality was not normal. R1 and R2 were sent out at the request of the psychiatric doctor.R2's Progress Notes dated 3/30/2026 at 5:11AM, shows R2 tried to take another resident's phone from him.R2's Progress Notes dated 3/30/2026 at 5:47PM, R2 started verbalizing profanity and instigating trouble towards other residents during lunch in the main lunchroom.R2's Progress Note date 3/31/2026 at 11:12AM, shows, hospital states R1 was admitted for Aggressive behavior psychiatry has already seen R1 and are planning treatment or transfer.R1/R2's Abuse Report dated 03/28/2026 shows R2 was attempting to go to room. R1 was blocking the hall. R2 used leg to move R1's wheelchair, a cup R2 hit R1's head.R2's Abuse Report statement dated 03/28/2026 shows, I was trying to get by in the hall to go to my room and R1 was blocking the hall. I asked R1 to move and R1 began yelling. Refused to move. I used my leg to push R1's chair out of the way. We were swinging our arms, and I had a plastic cup in my hand and hit R1 on head. I didn't mean to hurt R1, but R1 is difficult yelling and swearing.2. On 04/16/2026 at 11:44AM, R3 was sitting in a wheelchair.On 04/16/2026 at 11:44AM, R3 said, R4 threw a cup of coffee in face. R4 was in the doorway of the dining room. I asked R4 to move, R4 turned and threw coffee at me. R3/R4 Abuse Investigation dated 02/27/2026 shows, R3 and R4 were in wheelchairs attempting to pass into the dining room when R3 told R4 to get out of the way and R4 had a cup of [NAME] and tossed towards R3.R3's Abuse statement dated 02/27/2026 at 8:00AM, shows R3 states, was entering the dining room in wheelchair and R4 was just sitting in R4's wheelchair blocking the way for R3 to get to the table. R3 told R4 to move and wheelchairs hit each other. R4 had a cup with liquid and tossed towards R3. R3 states hit my face. Staff indicated it hit R3's arm.The facility's Abuse, Neglect and Exploitation policy dated (continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/07/2025 shows, it is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p>