

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 05/27/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to administer medications as ordered, at ordered times for 2 of 3 residents (R1, R3) reviewed for medication administration in the sample of 6. The findings include: 1. On 5/27/26 at 11:42 AM, R1 said he can recall receiving his meds very late last week. It was after 12PM when he finally got his morning medications. R1 said the nurse that was working was not on time giving his meds. Review of R1's Physician Order Sheet (POS) shows an order of: Valproic Acid Oral Capsule 250 mg (milligrams), Give 500 mg by mouth three times a day for seizures Take 2 capsules (250 x2=500mg) to be given at 9AM, 1PM and 2100 (9PM); Clonazepam Oral Tablet 0.5 mg, Give 0.5 mg by mouth two times a day for anxiety/ aggression to be given at 8AM and 4PM. Review of R1's Medication Administration Audit report shows that on 5/18/26, the morning dose of Valproic Acid that was supposed to be given at 9AM was given to R1 at 12:42 PM (more than 3 hours late). R1's morning dose of Clonazepam that was supposed to be given at 8AM, was given to R1 at 12:44 PM (more than 4 hours late). 2. On 5/15/26 at 8:45 AM, R3 said he did not receive his morning medications until approximately 1PM. R3 said he missed his lunch while waiting for his morning meds. R3 said he refused his noon medications because they would have been given too close together. Review of R1's POS shows an order for: Alprazolam 1 mg gives 1 tablet three times a day (TID) for anxiety to be given at 8AM, 2PM and 8PM. Dicyclomine 10 mg 1 capsule TID for abdominal discomfort cramping to be given at 8AM, 1PM and 6PM. Review of R1's Medication Administration Audit report show: On 5/18/26, the morning dose of alprazolam that was supposed to be given at 8AM was given at 12:58 PM (more than 4 hours late), the morning dose of dicyclomine that was supposed to be given was given at 12:53 PM (more than 4 hours late). On 5/27/26 at 12:20 PM, V3 (Licensed Practical Nurse-LPN) said she was an agency nurse, she worked last 5/18/26 day shift. V3 said she cannot recall the specific events that day. V3 said meds should be given at the prescribed time as ordered. On 5/27/26 at 10 AM, V6 Licensed Practical Nurse (LPN) said in this wing (100), residents were when they received their meds. Residents should be administered their medications an hour before or an hour after the scheduled time. The Facility Policy entitled Medication Administration dated 10/2025 showed Medications are administered by Licensed nurses or other staff who are legally authorized to do so in this state as ordered by the physicians and in accordance with professional standards of practice in a manner to prevent contamination or infection. Administer medications within 60 minutes (1 hour) prior to or after scheduled time unless otherwise ordered by the physician.		

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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