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	06/10/2026

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 a resident was not neglected from receiving nutrition, hydration and medications to manage medical symptoms. This failure resulted in R1 developing severe dehydration, sepsis and acute renal failure requiring hospitalization on 5/30/26. This applies to 1 of 9 residents (R1) reviewed for neglect in the sample of 9. The findings include: R1's EMR (Electronic Medical Record) shows that he was admitted to the facility on [DATE] with diagnoses including Hypertension, Muscle Weakness, Chronic Kidney Disease Stage 3, Acute Cystitis with Hematuria and Metabolic Encephalopathy.R1's Care Plan dated 5/27/26 shows that R1 has Imbalanced nutrition: Less than body requirements, related to lack of knowledge and inadequate food intake.R1's Hospital Notes dated 5/4/26 state, Discharge to Sub Acute Rehab: benefit from high frequency therapeutic program, demonstrating high level of burden on primary caregiver, demonstrating decline from prior level of functioning, increased risk of falls at home, risk of hospital re-admission. In all the hospital records provided by the facility and reviewed there is no mention of V11's (R1's Son) desire to admit R1 into hospice care.On 6/9/26 at 12:30PM V6 (Nurse Practitioner) stated, He came to us from (Local Hospital) following a UTI (Urinary Tract Infection). I saw him on May 11. He only speaks (a foreign language) and even his son had difficulty communicating with him. He had a history of Dementia and Anxiety. He was on meds for all of that. I contacted Psych for a consult. He was alert and he would respond to me in English. I saw him on the 14th. I used a translator so I could speak to him. I got a weight for him. No signs of fluid overload. I saw him again on 18th. (V11) was at the bedside. I was called in with concerns about his oral cavity. It looked fungal. At that time (V11) told me the patient has a poor appetite. I put him on Nystatin. (V11) told me he was having a runny nose. Then I saw him again on 5/21. I assumed the poor appetite was from the oral thrush. On 5/15 I did labs they were not much different from the hospital lab results. He was not dehydrated. On 5/21 I saw only slight improvement of thrush -because he was spitting out his meds. I called (V11)- I told (V11) to bring food from home and to be sure to tell the nurses when you do. I consulted the dietitian. I ordered a daily weight and a nutritional supplement and a calorie count. I told (V11) that (R1) was not responding to questions with the translator that day. On the 22nd I was told (R1) pulled out his catheter and he was sent to the ER /Emergency Room, and they gave him Haldol there and I saw him after. There was no blood in the urine, but it was dark yellow, and I ordered a follow up with urology. The next day I went on vacation. I spoke to the dietitian myself to let her know my concerns.On 6/9/26 at 1:20PM V1 (Administrator/Director of Nursing) stated, He was extremely agitated. We could understand some of what he was saying. He refused just about everything. (V11) was going between Hospice and other things. We left that with the son. When he came to us, he was supposed to be on hospice and the son rescinded it. We had hospice come in later. (R1) was declining very quickly. We did the care plan- (V11) thought IV (intravenous) fluid would help. We ended up transferring him out because the son was not making a decision. We were under the impression he was coming as a hospice patient, and the son was on the fence the entire time. It was in his hospital notes. We could not get a clear answer of what he wanted us to do.On 6/10/26 at 12:50PM V10 (R1's (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

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	06/10/2026

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Physician) stated, I was aware of the situation. I was under the impression that the initial goals of this patient were for him to be on hospice. The facility had been addressing the issue with the family. I remember vaguely getting the call from the nurse regarding his condition. I see a lot of patients every day. After seeing him (On 5/26) is when I started him on the bolus IV fluids. I think a part of why we were not really treating him was that the son was wanting hospice and we were waiting on hospice to evaluate him. Then he met with hospice and he decided against it. My understanding the whole time was that the family was considering hospice. I thought that was our goal. Without reviewing his chart and the trends I really can't comment any further on that.On 6/10/26 at 1:00PM V11 (R1's Son) stated, They gave him IV fluid because I asked them to. Then they gave him only one bag. I asked them why and they said that was all the doctor ordered. I offered to pay for the fluids out of my own pocket if that is what I had to do. There was some serious neglect going on there. It was a recommendation of them for him to go to hospice, but my goal was to keep him their long term. They convinced me to sell his house to pay for him to stay there. When I came in to visit, he took some fluids for me. I don't know if they really tried. No one should have to go through what he went through. They never talked about hospice until I talked to the doctor, and he recommended hospice. I told them I would listen to what they (hospice) had to say- which I did but then I decided that was not what I wanted for my dad. I absolutely wanted him treated from the day he got in there. A month ago, he was up walking and talking just like you or me. Now he is on hospice at the hospital because there is nothing more, they can do. Please do not let anyone else get hurt like that.R1's Progress Notes dated 5/10, 5/14, 5/20, 5/23-5/28 all show that R1 was not eating, taking fluids or taking medications. The notes all state that R1 is agitated and spitting out medications and food.R1's Medication Administration Record for May 2026 shows daily weights were ordered on 5/22/26. All weights are marked as refused or the box is blank from 5/22-5/30.R1's Dietitian Note dated 5/22/26 shows that R1 had poor intakes and was refusing nutritional supplements. The note states, TF (Tube feeding) or hospice.R1's Progress Notes dated 5/26/26 state, Writer contacted MD/Medical Doctor (V10) and updated regarding resident's current condition. Resident previously sent out for agitation and foley catheter dislodgment and returned to facility. Resident has had minimal dietary intake; staff attempts to feed and resident refuses. Resident has DTI (Deep Tissue Injury) and wound care nurse changed dressing. Resident is presenting to mottling to BLE (bilateral lower extremities). Resident is full code at this time. MD to be in facility and see resident today.R1's Physician Note from V10 dated 5/28/26 from visit on 5/26/26 states, Goals of care discussion will be had with patient's family tomorrow. I did discuss goals of care with the POA/Power of Attorney over the phone today. He is entertaining hospice. Would like to wait till tomorrow's family meeting or tomorrow's goals of care discussion to make final decision. In the meantime, palliative care / hospice services consulted. Underlying dementia / cognitive impairment. Continue supportive care. Monitor behavioral symptoms and safety awareness Acute cystitis with microscopic hematuria / recurrent UTI history. Monitor for recurrence of infection Follow urine culture results if pending. Encourage hydration Urology follow-up as needed. AKI (Acute Kidney Injury) on CKD stage III improving. Avoid nephrotoxic medications Monitor renal function and electrolytes. Encourage hydration as tolerated. IV Fluids ordered .R1's Progress Notes dated 5/30/26 state, Critical lab result Na (sodium) 176, BUN (blood urea nitrogen) 169 and K (potassium) 5.3 received from the lab notified (V10- R1's Physician) advised to call 911 send the resident to the hospital ER called and information given to (V11- R1's Son) he agreed to send to ER. Called 911 and they have taken him to the (Local) ER. All the needed information and documents handed over to them.R1's Progress Notes dated 5/30/26 state, Called (Hospital) ER, RN (Registered Nurse) told that the resident got admitted in the (Local Hospital) ICU/Intensive Care Unit with Sepsis, dehydration and Acute Renal Failure .

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	06/10/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify a resident's pressure injury prior to an advanced stage. This failure resulted in R1 being identified with a DTI (Deep Tissue Injury) to his bilateral buttocks on 5/20/26. This applies to 1 of 3 residents (R1) reviewed for pressure injuries in a sample of 9. The findings include: R1's EMR (Electronic Medical Record) shows that he was admitted to the facility on [DATE] with diagnoses including Hypertension, Muscle Weakness, Chronic Kidney Disease Stage 3, Acute Cystitis with Hematuria and Metabolic Encephalopathy. R1's Skin and Wound Note dated 5/13/26 written by V9 (Wound Nurse Practitioner) states, No wounds. On 6/9/26 at 9:44AM V2 (Assistant Director of Nursing) stated, He is not here anymore. It started with a DTI (Deep Tissue Injury) to his left buttocks. I put an assessment in wound rounds. He was not eating or drinking. Had a low air loss mattress. It was added the day we found the DTI. He was agitated and resistant to care. R1's Facility Skin Issues assessment dated [DATE] shows R1 has a new wound, unstageable pressure injuries presenting as deep tissue injury to the buttocks, present on admission, onset- unknown. The wound measures 14 x 13 x 0.1 cm (centimeter) and is comprised of 70% epithelial tissue, 10% granulation tissue and 20% eschar. The Wound Assessment Report done by V9 on 5/20/26 shows the wound measuring 14 x 13 x 0.1 cm to the bilateral buttocks, acquired in house on 5/18/26. The wounds are described as 100% intact epithelium with evidence of deeper tissue injury (maroon or darkened purplish discoloration) epithelial. R1's Facility Skin Issues assessment dated [DATE] shows that R1's wound to his buttocks is now in-house acquired, measures 11.80 x 11.20 x 0.2 cm and consists of 20% epithelial tissue, 20% slough and 60% eschar The Wound Assessment Report dated 5/27/26 done by V9 shows the wound measures 11.80 x 11.20 x 0.2 cm to the bilateral buttocks. It is unstageable and consists of 30% epithelial, 10% granulation, 30% slough and 30% eschar. On 6/10/26 at 8:40AM V9 stated, On 5/13 yes, he had no wounds on that visit. On 5/20, the wound was brought to my attention by the facility. It was a purple discoloration; it was a DTI. There was epithelial tissue and a small opening but no necrosis. It was kind of a maroon colored on both buttocks. On 5/27- He had eschar, slough and epithelial tissue. It was a DTI that had opened up. He had a lot of co-morbidities, impaired functional mobility, incontinence. I had him at moderate risk for pressure development. He had altered mental status, but he was able to turn without assistance. He was cooperative for me during the assessments. I guess when they saw it, they would have thought it was bruising or something. He was on a blood thinner. He was not eating much, and I know he was a possible candidate for hospice. R1's EMR show no mention of a skin assessment or identification of R1's wounds prior to 5/20/26.

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	06/10/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a psychotropic medication order was transcribed to the medication administration record. This failure resulted in R1 not receiving the medication for the purpose of managing R1's behaviors and improving his quality of life. This applies to 1 of 1 resident (R1) reviewed for significant medication errors in the sample of 9. The findings include: R1's EMR (Electronic Medical Record) shows that he was admitted to the facility on [DATE] with diagnoses including Hypertension, Muscle Weakness, Chronic Kidney Disease Stage 3, Acute Cystitis with Hematuria and Metabolic Encephalopathy.R1's Progress Note written by the Psychiatric Nurse Practitioner dated 5/22/26 states, Patient is noncompliant with oral medications, limiting effectiveness of current PO regimen. Initiate ZyPREXA (olanzapine- an antipsychotic) 5 mg (milligrams) IM (intramuscularly) every 8 hours PRN (as needed) for anxiety/agitation for 7 days. Continue behavioral interventions including redirection, reassurance, low-stimulation environment, and consistent caregiving approach. Encourage continued attempts at oral medication administration when safe and feasible .R1's Progress Notes dated 5/23/26, 5/24/26, 5/25/26, 5/26/26, 5/27/26 and 5/28/26 all shows that R1 was having aggressive, combative behaviors, spitting out his food and oral medications. R1's Medication Administration Record for May 2026 shows no order for Zyprexa. This same document shows that R1 has no documented behaviors in the month of May. (Inconsistent with R1's Progress Notes.)R1's Care Plan dated 5/22/26 does not address R1's aggressive behaviors or refusal of food, fluids or medications. On 6/10/26 at 10:30AM V1 (Administrator/Action Director of Nursing) stated, The nurse practitioner usually sends us a separate email after she sees the resident. I will look into this and see what happened. At 11:25AM V1 presented Surveyor with a copy of the email addressed to V1 and V2 (Assistant Director of Nursing) showing the order for the Zyprexa (Antipsychotic). V1 stated, It was never given- that medication is for schizophrenia which he did not have. That is the regulation. He already had all of these other medications on board and that was not something he needed. It never got ordered. The son would have had to have to agree to that also. The facility policy dated 10/2025 states, Psychotropic medications are to be used only when the practitioner determines that the medication is appropriate to treat a resident's specific diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated be monitoring and documentation of the resident's response to the medication.

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	06/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure that dietary staff change their gloves during food service after coming in contact with potentially dirty objects/areas to prevent cross contamination. This has the potential to affect all 73 residents in the facility. The findings include: On 6/9/26 at 11:40AM V5 (Head Cook) was checking food temps with a thermometer at the steam table in the kitchen. V5 was wearing gloves. V5 reached up and touched his glasses with his gloved hand and then continued to check temperatures. V5 then rubbed the side of his nose, opened the service window door, and rubbed his eye wearing the same gloves. Without changing his gloves V5 then started stacking plates and bowls onto the counter getting ready for service. V5 was speaking to Surveyor and resting his gloved hand on the top plate. V5 picked up his notebook used for collecting food temperatures and put his notebook back in the pocket of his apron. V5 then touched his glasses again. Without removing the gloves V5 began serving the noon meal. V4(Dietary Manager) asked V5 for a chopped chicken piece. V4 removed the chicken from the steam table pan and placed it on the counter in front of him. V5 Cut the chicken and then scooped it with his gloved hand onto a plate. We do sanitize the counter before we start. V4 wore the same pair of gloves throughout the entire meal service. On 6/9/26 and 12:17PM V4 stated, We should be changing gloves between everything we do when we are serving the food. The servers do not wear gloves, but we do wear them when serving from the steam table and they should be changed between everything that we do. On 6/9/26 at 1:30PM R9 stated, (V4) in the kitchen is always touching his face with his gloves on and then serving the food.The Facility Data Sheet dated 6/9/26 shows that there are 73 residents residing in the facility. The facility policy entitled Gloves for Food Handling dated 2025 states, The gloves should be discarded when damaged, torn, soiled, or when interruptions occur or when handling something beyond the scope of food prep.