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	06/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review the facility failed to safely transfer a resident. This failure resulted in R3 sustaining an ankle fracture that required surgical repair. This applies to one of three residents (R3) reviewed for safety in the sample of three.The findings include:The facility face sheet for R3 shows she was admitted to the facility with diagnoses to include but not limited to Stage 5 kidney disease, Type 2 Diabetes, and other specified disorders of bone density. The facility assessment dated [DATE] shows R3 to be cognitively intact and requires maximum assistance from staff with transfers from bed to chair.A facility reported incident report dated 6/4/26 shows R3 was being assisted out of bed by a staff CNA (Certified Nursing Assistant) and when R3 stood up from her bed her legs became weak, and she twisted her left ankle, and the CNA lowered her to the floor. The report shows R3 was sent to the local hospital where it was discovered she had sustained a fracture on her left ankle. R3 was returned to the facility on 6/7/26 after having surgery to repair the broken ankle.On 6/23/26 at 10:01 AM, R3 said V2 CNA was helping her get ready for her dialysis treatment and she was sitting on the edge of the bed when she told V2 she was feeling weak and to not let her fall. R3 said V2 never put a gait belt on her before she began to transfer to the wheelchair. R3 said V2 put her arms under her arms and helped her to stand up. R3 said she began to feel her leg give out and remembers screaming don't let me fall. R3 said V2 attempted to hold her up but she couldn't, and she fell to the floor.On 6/23/26 at 10:14 AM, V2 CNA said she was assisting R3 out of bed to get ready for her dialysis. V2 said R3 was usually independent with her transfers but just needed supervision. V2 said she put a gait belt on R3 and then put her arms under R3's arms and helped her to stand up. V2 said R3's legs gave out and she lowered R3 to the floor. When asked why she was putting her arms under the residents' arms she said, I always do this as a precaution.On 6/23/26 at 9:27 AM, V3 CNA said he responded to V2's calls for help after R3 was lowered to the floor. V3 said he helped get R3 off the floor after she was assessed by the nurse. V3 said he believed R3 had a gait belt on but could not be sure.On 6/23/26 at 10:38 AM, V4 LPN (Licensed Practical Nurse) said she was the nurse assigned to R3 the day she fell in her room. V4 said she had told V2 that day to take extra precautions with R3 that day because she often gets weak because of her dialysis treatments. V4 said extra precautions would include using another staff person and using a gait belt. V4 said when she walked into the room, she saw R3 on her bottom next to her bed. V4 said she could not recall if a gait belt was on R3. V4 said R3 was complaining of mild pain to her ankle, but after a few minutes she began to complain of more pain. V4 said she gave R3 something for the pain and then called the provider for instructions. V4 said the Administrator came to the room and said R3 needed to be transferred to the hospital and that is what she did.On 6/23/26 at 1:26 PM, V1 Administrator said a resident who is a one person stand by assist should have a staff member at the side of the residents and have their hands gently on the gait belt as the resident is moving between bed and chair.The hospital records for R3 show she was admitted to the hospital on [DATE] with a left trimalleolar (a break to the ankle joint) fracture. The record shows R3 had an ORIF (Open reduction internal fixation) surgery on her left ankle on 6/5/26.The care plan with a revision date of 4/7/25 for ambulation shows interventions to include (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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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	adaptive equipment such as a walker and gait belt. Instruct on proper use for safety. The care plan does not show any directions for transfers prior to the fall on 6/3/26.The facility policy dated 10/2025 for safe resident handling/transfers shows it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident.