

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000864		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2026	
NAME OF PROVIDER OR SUPPLIER La Bella of Woodstock				STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE , WOODSTOCK, Illinois, 60098			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments First Probationary Licensure Survey Complaint Investigation: 2610971/2724189		S0000			02/12/2026	
S9999	Final Observations Statement of Licensure Violations 1 of 8: 300.625c)1)2 Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to identify an identified offender, schedule fingerprinting with 72 hours of admission and report		S9999			02/12/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Illinois State Department of Health

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S9999	Continued from page 1 the offender to the Identified Offender Program for 2 of 10 residents (R12 and R13) reviewed for identified offender in the sample of 15. The findings include: R12's Face Sheet shows that he was admitted to the facility on 12/24/25. R12's UCIA name-based background check dated 12/24/25 shows that he had a hit for domestic battery with bodily harm. R13's Face Sheet shows that he was admitted to the facility on 1/13/26. R13's UCIA/Uniform Conviction Information Act name-based background check dated 1/22/26 shows that he had a hit for domestic battery with bodily harm. On 1/27/26 at 10:50 AM, V9 (Social Service Director) said that she does not have access to the Identified Offender Portal but has requested access. On 1/27/26 at 1:32 PM, V20 (MDS/Minimum Data Set Coordinator) said that she does not know who is responsible for requesting fingerprints for residents but R12 and R13's fingerprints were not done but will be done soon. V20 said that no one at the facility currently has access to the Identified Offender Portal. The facility's Illinois Identified Offenders Background Screening and Submission Procedure dated 10/2024 shows, "If the results of a resident's UCIA name-based criminal history background reveals that the resident is an identified offender, as defined in Section 1-114.01 of the Nursing Home Care Act, the facility shall, within 72 hours, arrange for a Fee Applicant (FEAPP) fingerprint-based criminal history record inquiry.....within 24 hours of the Livescan appointment, the facility must notify the Identified Offenders Programs using the online application...." (C) Statement of Licensure Violations 2 of 8: 300.626c) Section 300.626 Discharge Planning for Identified Offenders c) When a resident who is an identified offender is discharged, the discharging facility shall notify the			S9999			

Illinois State Department of Health

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S9999	Continued from page 2 Department. These requirements were not met as evidenced by: Based on interview and record review the facility failed to notify the Identified Offender Program once a resident discharged from the facility for 1 of 1 resident reviewed for identified offender discharges in the same of 15. The findings include: R15's Face Sheet shows that he was discharged from the facility on 1/8/26. The Identified Offender Program Facility Report dated 1/21/26 shows that R15 is still a resident at the facility. On 1/27/26 at 10:50 AM, V9 (Social Service Director) said that she does not have access to the Identified Offender Portal but has requested access. On 1/27/26 at 1:32 PM, V20 (MDS Coordinator) said that no one at the facility currently has access to the Identified Offender Portal to discharge any residents." (C) Statement of Licensure Violations 3 of 8: 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure the IDPH Health Care Worker Registry (HCWR) was checked for 5 of 10 employees prior to employment and failed to obtain fingerprinting services (Fee App) within 10 days of hire for 2 of 10 employees. These failures have the potential to affect all 77 residents in the facility. The findings include: The facility's Resident Roster dated 1/26/26 shows 77 residents currently live in the facility.			S9999			

Illinois State Department of Health

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S9999	Continued from page 3 The facility's list of employees with their date of hire provided by the facility (undated) shows V21 was hired on 11/6/25. V21's IDPH HCWR was checked on 12/16/25. The facility's list of employees with their date of hire provided by the facility (undated) shows V22 was hired on 11/12/25. V22's IDPH HCWR was checked on 12/15/25. The facility's list of employees with their date of hire provided by the facility (undated) shows V23 was hired on 12/8/25. V23's IDPH HCWR was checked on 12/15/25. The facility's list of employees with their date of hire provided by the facility (undated) shows V24 was hired on 11/24/25. V24's IDPH HCWR was checked on 12/15/25. The facility's list of employees with their date of hire provided by the facility (undated) shows V25 was hired on 11/13/25. V25's IDPH HCWR was checked on 12/15/25. V25's Fee App was performed on 12/17/25. The facility's list of employees with their date of hire provided by the facility (undated) shows V26 was hired on 10/2/25. V26's Fee App was performed on 10/22/25. On 1/27/26 at 1:58 PM, V11, Human Resources Director, said she does the health care worker background checks after the applicant accepts the position, which includes checking the HCWR. V11 said if the employee needs to be fingerprinted, then she sends them when doing the onboarding paperwork. V11 said the fingerprinting needs to be completed 10 days from the date of hire. V11 said they don't know if the employees are eligible to work until the fingerprinting is back which is why they need to be done within 10 days of hire. The facility's Background Investigations Policy (reviewed 10/13/25) shows the Human Resources department will conduct all applicable background investigation(s) on each individual making application for employment with the company. (C) Statement of Licensure Violations 4 of 8: 300.696d)14)			S9999			

Illinois State Department of Health

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S9999	Continued from page 4 Section 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 14) Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP) for 1 of 4 residents (R7) reviewed for infection control in the sample of 15. The findings include: On 1/26/26 at 9:51 AM, R7's room was noted to have a sign for Enhanced Barrier Precautions (EBP) and a Personal Protection Equipment (PPE) bin outside the room. On 1/26/26 at 9:57 AM, V17, Certified Nursing Assistant (CNA), entered R7's room. Wearing gloves and no gown, V17 made R7's bed and then brushed R7's hair. On 1/26/26 at 10:04 AM, R7 said she is getting ready to go to dialysis. On 1/26/26 at 1:03 PM, V14, Licensed Practical Nurse (LPN), said anyone with a fistula, port or wound needs to be on EBP. If a resident is on EBP, they will have a sign on the door. Staff need to wear a gown and gloves with any direct patient care of a resident on EBP. On 1/26/26 at 1:55 PM, V12, Infection Prevention Nurse, said EBP are for residents with an AV fistula, a catheter, a g-tube or a pressure wound. When staff provide any personal care to a resident on EBP, staff need to wear a gown and gloves. Personal care includes changing/making a bed, providing hair grooming and assisting with activities of daily living. R7's Physician's Orders show she has a current order written on 10/20/25 for EBP per policy for a hemodialysis (HD) catheter. The facility's Isolations list for January 2026 shows			S9999			

Illinois State Department of Health

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S9999	Continued from page 5 R7 is on EBP for an AV shunt and catheter. The facility's Enhanced Barrier Precautions Policy (not dated) shows it is the policy of the facility to implement EBP for the prevention and transmission of multidrug-resistant organisms. An order for EBP will be obtained for residents with any indwelling medical devices such as hemodialysis catheters. Gown and glove use is employed when performing high contact care activities such as changing linens, dressing, and providing hygiene. (B) Statement of Licensure Violations 5 of 8: 300.1060c) 300.1060d) 300.1060f) 300.1060g) Section 300.1060 Vaccinations c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act) f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) These requirements were not met as evidenced by:			S9999			

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S9999	Continued from page 6 Based on interview and record review the facility failed to offer or document refusal against the pneumococcal vaccine upon admission, failed to screen for risk factors associated with hepatitis B, hepatitis C, and HIV and determine if they have received the hepatitis B vaccinations, and failed to offer the hepatitis B immunization upon admission for 5 of 5 residents (R1, R4 and R7-R9) reviewed for immunizations in the sample of 15. The findings include: 1.R1's Face Sheet shows that she admitted to the facility on 11/21/23. R1's Immunization Summary does not document that she has had a pneumococcal vaccine nor refused a pneumococcal vaccine. R1's Immunization Summary does not document that she has had the hepatitis B immunization nor that she has refused the hepatitis B immunization. 2. R8's Face Sheet shows that he admitted to the facility on 11/5/24. R8's Immunization Summary does not document that she has had a pneumococcal vaccine nor refused a pneumococcal vaccine. R8's Immunization Summary does not document that she has had the hepatitis B immunization nor that she has refused the hepatitis B immunization. 3. R4's Face Sheet Shows that she was admitted to the facility on 8/23/25. R4's Immunization Summary does not document that she has had the hepatitis B immunization. 4. R7's Face Sheet Shows that she was admitted to the facility on 10/9/22. R7's Immunization Summary does not document that she has had the hepatitis B immunization. 5. R9's Face Sheet Shows that she was admitted to the facility on 3/3/22. R9's Immunization Summary does not document that she has had the hepatitis B immunization. On 1/26/26 at 1:41 PM, V12 (Infection Preventionist) said that the pneumococcal vaccination status of each resident is assessed upon admission and the vaccine is		S9999				

Illinois State Department of Health

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S9999	Continued from page 7 offered if they are not up to date according to the CDC (Center for Disease Control and Prevention). V12 said that residents are not screening for their risk for hepatitis B, hepatitis C or HIV upon admission and have not been offered the hepatitis B immunization within 10 days of admission. The facility's Pneumococcal Vaccine Policy dated 10/13/25 shows, "Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized... The resident/representative retains the right to refuse the immunization. The facility will document in the clinical record the reason for refusal or the medical contraindication of the immunization...." (B) Statement of Licensure Violations 6 of 8: 300.1210d)2)5)6) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.		S9999				

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S9999	Continued from page 8 These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure oxygen tubing was changed as ordered, failed to implement pressure ulcer prevention interventions and failed to have fall safety interventions in place for 5 of 11 residents (R5, R6, R8, R9 and R10) reviewed for Nursing Care in the sample of 15. The findings include: 1. On 1/26/26 at 9:35 AM, R5 was laying in bed. R5 had oxygen on and the oxygen tubing was not labeled. R5 said that his tubing was changed about 3 weeks ago. R5's January Medication Administration Record (MAR) shows an order for, "Oxygen via nasal cannula at (3) liters/minute-every night shift every Sun (Sunday) change tubing/humidifier/storage bag." R5's MAR shows that it was not changed on Sunday, 1/25/26 and it was last changed on 1/11/26. 2. On 1/26/25 at 9:50 AM, R9 was lying in bed with oxygen in place. R9's oxygen tubing was dated 1/13/26. R9's MAR does not show an order to change her oxygen tubing weekly. 3. On 1/26/26 at 9:51 AM, R8 was asleep in bed. Next to his bed was an oxygen concentrator, the nasal cannula tubing had tape with the date 1/12/26 written on it. R8's Physician Order Summary shows he has an active order for oxygen via nasal cannula and weekly tubing changes. R8's Medication Administration Summary (MAR) shows that his oxygen tubing should be changed weekly on Mondays. The MAR also shows that it was initialed that it had been changed on 1/19/26 even though the tubing was still dated 1/12/26. On 1/26/26 at 1:43 PM, V2 (Director of Nursing) said that all oxygen tubing should have an order in the system to replace it weekly. V2 said that the order carries over to the MAR to be signed off when it is done. The facility provided Oxygen Administration policy dated 10/13/25 shows that oxygen tubing and mask or cannula should be changed weekly and as needed.		S9999				

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S9999	Continued from page 9 4. R6's face sheet shows she has diagnoses including: Vascular Dementia, weakness and protein calorie malnutrition. R6's Pressure Ulcer Risk Assessment completed on 1/6/26 shows she makes limited position movements and is at high risk to develop pressure injuries. R6's current care plan shows on 1/6/26 an intervention for R6 to have an air-mattress on her bed was added. The care plan also shows that R6 had a history of a pressure injury to her coccyx and redness to her right heel both show they were recently resolved on 1/16/26. A skin and wound note completed on 1/23/26 by V12 (Infection Preventionist and Wound Care Nurse) shows that R6 currently has blanchable redness to her coccyx. On 1/26/25 at 9:32 AM, and again at 1:03 PM, R6 was lying in bed in her room. Her air mattress was powered off both times. On 1/26/26 at 1:55 PM, V12 said that R6 did have a recent pressure injury and currently has redness to her coccyx. V12 said she has an air mattress on her bed, that should be on when she is in bed, and R6 is at risk for pressure and on hospice care. The facility provided Pressure Injury Prevention and Management policy dated 10/13/25 shows that interventions should be in place including pressure-redistributing and support surfaces for residents at risk for pressure. 5. On 1/26/26 at 9:32 AM, R6 was in bed. Across the room were folded up fall mats. R6 began to sit up when this surveyor entered the room and appeared to be confused and asked to stand to get into her wheelchair which was next to her bed. At 1:03 PM R6 was again in bed with the same fall mats folded up and across the room. On 1/27/26 at 10:18 AM, V13 Certified Nursing Assistant/CNA said any time R6 is in bed her fall mats should be on the floor next to each side of her bed. V13 said R6 is confused at times and is risk for falling. R6's current care plan shows she has dementia, had a fall prior to admission, is at risk for falls and should have bilateral fall mats by her bed. R6's Fall Risk Assessment completed on 1/6/26 also shows she is at very high risk for falls.			S9999			

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S9999	Continued from page 10 The facility provided Fall Prevention policy dated 10/13/25 shows that interventions should be implemented from the care plan to help minimize falls. 6. On 1/26/26 at 9:54 AM, V18, Certified Nursing Assistant (CNA), assisted R10 from the toilet to a standing position while V18 wiped her and put on a clean brief. V18 then assisted R10 into her wheelchair. V18 did not use a gait belt to assist R10 with the process of standing and transferring. R10 was only wearing a gown. On 1/26/26 at 1:03 PM, V14, Licensed Practical Nurse (LPN), said when transferring a resident from the toilet to the wheelchair or from the wheelchair to the toilet, staff need to use a gait belt for safety. On 1/26/26 at 1:58 PM, V2, Director of Nursing (DON), said if staff are assisting a resident to transfer, they need to be using a gait belt. R10's Admission Record dated 1/26/26 shows her diagnoses include, but are not limited to, generalized muscle weakness, difficulty in walking, polyneuropathy, chronic pain, osteoarthritis, chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. R10's Minimum Data Set dated 11/11/25 shows R10 requires substantial/maximal assistance with toileting hygiene, sit to stand, and toilet transfers. R10's current care plan provided by the facility shows R10 is at risk for falls. R10's most recent Morse Fall Assessment dated 8/7/25 shows R10 is a moderate risk for falling and cannot ambulate unassisted. The facility's Use of Gait Belt Policy (reviewed 10/13/25) shows it is the policy of the facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety." (B) Statement of Licensure Violations 7 of 8: 300.3210a)2)A) Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United 2) Residents shall have their basic human needs, including but not limited to water, food, medication,			S9999			

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S9999	Continued from page 11 toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was provided with eating utensils as a means to eat in a dignified manner and given a call light for 1 of 15 residents (R14) reviewed for dignity and quality of life in the sample of 15. The findings include: On 1/27/26 at 8:15 AM, R14 was lying in bed with his breakfast of bite sized toast, sausage and eggs on the over bed table. R14 said he had to eat his meal with his fingers because he did not get any eating utensils, and he got yolk all over himself. R14 had no silverware, egg yolk and bits of egg were on his gown, and his call light was not within his reach as it was on the cabinet adjacent to his bed. On 1/27/26 at 8:16 AM, V18, Certified Nursing Assistant (CNA), said the CNAs pass the meal trays and R14 should have had silverware. R14's Admission Record dated 1/27/26 shows R14's diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. R14's Order Summary Report dated 1/27/26 shows an active order for a regular texture diet with double meat and eggs at breakfast; meals to be provided in soft, bite-sized pieces. The facility's Resident Rights Policy (reviewed 10/13/25) shows the resident has the right to a dignified existence and access to services inside the facility. The resident has a right to be treated with respect and dignity and the right to receive services in the facility with reasonable accommodation of their needs. (B) Statement of Licensure Violations 8 of 8:		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000864		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2026	
NAME OF PROVIDER OR SUPPLIER La Bella of Woodstock				STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE , WOODSTOCK, Illinois, 60098			
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S9999	Continued from page 12 300.610a) 300.1210b) 300.1210d)1)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.			S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000864		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2026	
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S9999	Continued from page 13 Based on observation, interview, and record review the facility failed to provide R3, a resident assessed to have a high level of pain, with pain medication for 1 of 5 residents reviewed for pain in the sample of 15. This failure allowed R3's pain from a traumatic rib fracture go untreated in the facility from 1:00PM to 6:49PM. The findings include: On 01/26/2026 at 11:30AM, On 01/26/2026 R3 was not in the facility. On 01/26/2026 at 9:23AM, R3 said, "I fell at home. I was discharged from the hospital with multiple rib fractures. I was using intravenous hydromorphone in the hospital to control the pain. I was admitted to the facility for rehabilitation and pain control. I had pain 20 out of 10. I waited 7.5 hours to get a pain pill. The facility had pain medication available but something about the rules would not allow them to treat me. I was in a lot of pain. I could not even open the door to the room I hurt so bad. I called my friend to pick me up and left. The nurse said I was leaving against their will. What "WILL"? I had no idea what their will was, no one saw me." V3 RN-Registered Nurse said, "(R3) arrived at the facility during medication pass. I needed to finish the medication pass before putting in (R3's) orders. (R3's) admission gave me resident number 30. This hall is a challenge, admitting a new resident makes it more difficult. I did not put (R3's) orders in fast enough. We did not have (R3's) pain medication on hand. It took quite a few hours for (R3) to get treatment for the pain. The medication was provided on the second shift around 7:30PM. The physician was called at 7:00PM, shift change. (R3) left the facility against medical advice." On 01/27/2026 at 11:11AM, V4 NP-Nurse Practitioner said, "I assessed (R3) on 01/19/2026 at 4:21PM, (R3) rated the pain 9/10. (R3) had multiple left rib fractures. The fractures extended from rib number 6 to rib number 9. (R3's) number one diagnosis was Rib Fracture; R3's second diagnosis was, Pain. I was notified around 6:00PM, the facility did not have (R3's) pain medications available. If I would have been		S9999				

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S9999	Continued from page 14 notified sooner, I would have provided an alternative pain medication immediately." On 01/27/2026 at 3:48PM, V12 RN said, "Zero is no pain, 10 is the worst pain ever." R3's Vital Sign Record shows, Pain: on 01/19/2026 at 1:00PM, 8/10, at 5:44PM, 8/10. R3's Medication Administration Record dated January 19, 2026 shows, R3 was provided with her first dose of pain medication at 6:49PM. The facility's Pain Management policy dated 10/01/2025 shows, Acute Pain refers to pain that is usually sudden in onset...caused by injury, trauma, or medical treatments...Policy Explanation: to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage Pain... (B)		S9999				