STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012975	A. BUILDING: _____ B. WING _____	C 07/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA STREAMWOOD	815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107

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S 000	Initial Comments Complaint Investigation 2183702/IL134367 2184086/IL134863 2194390/IL135248	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: These failures resulted in two deficient practice statements. 1. Based on observation, interview, and record review, the facility failed to follow their care plan interventions to monitor and supervise a cognitively impaired resident with a history of falls and failed to follow the facility's fall policy of implementing interventions for a personal bed and/or wheelchair alarm device. These failures affect one (R2) of four residents reviewed for falls and resulted in R2 having an unwitnessed fall, then not being monitored according to the plan of care. R2 was subsequently found unresponsive and pronounced dead at the facility. 2. Based on observation, interview, and record review, the facility failed to provide required assistance with bed mobility during incontinence care for one (R1) of four residents in the sample. This failure resulted in R1 rolling out of bed and sustaining a knee fracture and emergent transfer to an acute care hospital. Findings include: 1. R2 was a 70 year old cognitively-impaired resident with diagnoses including but not limited to vascular dementia with behavioral disturbance, right leg below the knee amputation, and end stage renal disease. Care plan dated 3/22/21 states in part: (R2) is	S9999		

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S9999	Continued From page 3	S9999		

high risk for falls related to cognitive impairment, decline in functional status, impaired balance during transitions, missing limbs. Interventions: Bed/chair alarm to alert staff when resident attempts to get out of bed/chair unassisted, so staff can assist resident and prevent falls; visually check me every hour, or more frequently as determined by care team; make sure that my call light is within my reach and encourage me to use it for assistance as needed."

Records document R2 with a previous unwitnessed fall that occurred on 3/21/21 where R2 was found on the floor beside the bed and on 4/6/21 where R2 was again found on the floor beside the bed.

On 6/30/21 at 10:10 AM, V2 (Director of Nursing) stated, "(R2) was found unresponsive by the nurse (V11/Registered Nurse/RN) at around 6:00 in the morning and wasn't informed by the previous nurse (V12) that R2 had fallen. (V11) didn't continue any neuro-checks (brief neurological exam) on the resident which the nurse (V11) should have continued. He also didn't inform the doctor or the family {of the fall}."

On 6/30/21 at 11:45 AM V12 (RN) stated, "(R2) was on the bathroom floor in an empty bedroom at the end of the hall. I was the only nurse on duty and was at the opposite end of the unit from where R2 was found. V18 (Certified Nursing Assistant/CNA) told me she found R2 on the bathroom floor and there was stool on the toilet bowl. I tried to do an assessment of R2 and checked him for injuries, but he is confused so he couldn't tell me what happened. We put him back in his wheelchair and brought him back to his room and put him back to bed. I started neuro-checks on him." Surveyor asked if he

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S9999	Continued From page 4	S9999		

heard any alarm go off that drew him to find R2. V12 stated, "No, he was heard yelling for help and V18 went in and saw (R2) on the ground in the bathroom and so she called me to tell me and we picked him up from the ground back to his wheelchair." Surveyor asked if he informed the doctor of R2's unwitnessed fall to obtain further orders. V12 stated, "I didn't call the doctor or the family because the phones weren't working. I also forgot to endorse (inform) to the next shift nurse (V11) about the fall incident." Surveyor asked what fall prevention measures were in place for R2. V12 stated, "I know he's a fall risk and has to be supervised. We just have to watch him more closely that's all."

On 6/30/21 at 1:35 PM, V11 (RN) stated, "When I started my shift that night at around 11:20 (PM) I didn't get a report from the previous nurse (V12) who was on duty and he already left the building. V12 never told me that R2 fell earlier, so I didn't conduct any neuro-checks or was told anything that happened to him. I found (R2) at 6 AM and he was unresponsive and was drooling. I immediately checked his blood sugar because I knew he was diabetic and received dialysis. I then called 911 and when the paramedics came, I overheard them saying he's already gone."

Nursing progress note by V12 (RN) on 6/11/21 at 7:51 PM (written over 13 hours after R2's death) stated in part, "This is a late entry of incident on June 10, 2021 at about 8:30 PM to allow for further investigation. As per CNA report, resident was noted calling for help. Staff went immediately to the resident to check. Resident was noted inside the washroom. Resident was in sitting position beside the toilet bowl facing the door. Head to toe assessment done. No visible injuries or bumps noted. Neuro-check every 15 minutes

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S9999	Continued From page 5 was initiated with resident denying pain when asked upon each assessment. Resident was assisted back to the wheelchair. Resident was assisted back to bed. Neuro-check was continued, initial blood pressure was elevated 172/111 at about 8:30 PM. Blood pressure was monitored and it went down to 139/79 at about 8:45 PM. Resident with no further complaints and slept until the end of the shift." There were no nursing entries written by V12 (RN) to show that he immediately informed the doctor, family, or any facility staff member of the of R2's unwitnessed fall incident that occurred on his shift. Emergency Medical Services record dated 6/11/21 at 6:11 AM stated in part, "Responded for the full arrest at facility. Upon arrival paramedics assessed patient to determine no further resuscitation was needed and medical control contacted for a time of death. Scene/body left in care of Police Department Officers." Policy dated 8/2020 titled "Fall Occurrence" states in part, "It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent the resident from falling. Those identified as high risk for falls will be provided interventions to prevent falls. If a resident had fallen, the resident is automatically considered as high risk for falls. An incident report will be completed by the nurse each time a resident falls. The falls coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall." 2. On 7/1/21 at 11:20 AM, V2 (Director of Nursing) stated, "We had a fall incident (6/23/21)	S9999		

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S9999	Continued From page 6 that I reported to your office regarding (R1). She (R1) is currently in the hospital and we are aware that she got a fracture. V16 (Certified Nursing Assistant/CNA) was changing her brief and (R1) was in a side-lying position when she asked to get some more lotion put on her legs. When V16 reached for the lotion, R1 slid down from the bed and fell to the floor. There was only V16 in the room with her as she only needs one person assist for bed mobility." Facility incident report completed by V10 (Falls Prevention Nurse) wrote (in part), "At around 4:40 am, CNA (V16) was changing resident's brief while resident was in bed. Resident was positioned on her right side and had asked the CNA to apply more lotion on her legs before lying on her back. While CNA reached for the lotion, resident was observed sliding off the side of the bed landing on her buttocks. Nurse on duty was notified immediately and upon entering the room, resident was observed sitting on the floor on the right side of her bed with head resting on the side of the bed. Head to toe and range of motion assessments were completed, resident complained of pain to left hip area. 911 was called. Hospital follow-up was done, and resident was admitted with diagnosis of left knee fracture." V16 (CNA) was not available for interview and did not return any calls from surveyor and V2. R1 is an alert and oriented 84 year old with diagnoses including but not limited to Parkinson's disease, Alzheimer's disease, and chronic obstructive pulmonary disease. MDS (Minimum Data Set) dated 4/15/21 documents R1's bed mobility required a 2-person staff assistance to turn and reposition while in	S9999		

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S9999	Continued From page 7 bed. Fall risk assessment dated 6/23/21 documents R1 with a score of 19 and considered high risk for falls (according to the risk assessment provided). There were no prior fall risk assessments shown in the records or provided to surveyor. Care plan revised on 5/19/21 by V17 (Restorative Nurse Director) documents, "Resident requires assistance with activities of daily living (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting). Transfers with mechanical lift & 2-person assist from bed to wheelchair. Bed mobility maximum assist." On 7/1/21 at 11:45 AM, V17 stated, "(R1) required a 2-person staff assist to turn left and right while in bed. She is limited in her ability to scoot up the bed and she still needs that 2-person assist. I was informed of her fall out of bed and was told she slid out of bed, but we did not consider her a fall risk. There should have been 2 CNA's (Certified Nursing Assistants) when they were changing her brief. I did hear that there was only one aide. It's possible that the bed was high up too when she was being changed. The one aide had to roll her to her side so that's when she rolled out of bed and fell to the ground. I do not believe she slid to the floor given her injury." Emergency room records dated June 23, 2021 at 3:18 PM documents in part, "The patient (R1) is an 84 year old female who was dropped out of her bed this morning when they were attempting to change her [brief]. She rolled over and fell to the floor, complained of some discomfort to the lower back and buttocks. Diagnostic results: 1. Fracture/dislocation of the distal left femur/proximal tibia (bone above knee/shin	S9999		

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S9999	Continued From page 8 bone). Procedure: Fracture/Dislocation. Technique: attempted reduction with traction counter-traction as well as manipulation; without success. Critical Care Note: Patient is unstable at presentation and required my full and direct attention, intervention and personal management for 60 minutes of critical time including time spend performing procedures. There is imminent risk of deterioration of the cardiovascular systems." (A)	S9999		