

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2022
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NAME OF PROVIDER OR SUPPLIER BELLA TERRA STREAMWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST IRVING PARK ROAD STREAMWOOD, IL 60107
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S 000	<p>Initial Comments</p> <p>Complaint Survey: 2295775/IL 149337 2295259/IL 148715</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility 1) failed to supervise a resident who is a high risk for falls. This failure resulted in R3, sustaining a subdural hematoma (brain bleed) and laceration to the back of her head requiring staples. Based on interview, observation and record review the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>facility 2) failed to put interventions in place for a resident who is a high risk for falls. This failure resulted in R4 sustaining a lumbar fracture requiring hospitalization. This applies to 2 of 4 residents (R3 and R4) reviewed for falls.</p> <p>The findings include:</p> <p>1. R3's Physician Order Sheet dated 8/22 show R3 has diagnoses that include dementia of Alzheimer type and end stage renal disease.</p> <p>R3's facility assessment dated 7/19/22 show R3 is severely cognitively impaired and needs extensive assist with bed mobility and transfers. A Fall Risk Assessment dated 8/6/22 show R3 was a high risk for falls.</p> <p>A progress notes dated 7/2/22 timed at 9:18 PM, V10 (Registered Nurse) documents "The writer heard the bed alarm going off...In the hallway while walking towards resident's room heard the sound that she fell. Noted resident on the floor laying on her back and noted moderate bleeding from her head, kept her in same position and placed a pillow under head, Resident stated that she is feeling dizzy but no pain at this time. Vitals done and called 911, [Physician] notified of the fall and POA notified of the fall and injury. Sent to ER."</p> <p>A hospital record dated 7/3/22 show "75 yr old female presented to the emergency department., ...HTN, Chronic renal failure, renal transplant known dementia aware of family members but confused as baseline per report, brought in after found on floor in nursing home. Pt had lacerated wound on back of her head."</p> <p>A Radiology report dated 7/3/22 show R3's CT of</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>the head results 13-millimeter mm thick subdural hematoma (brain bleed).</p> <p>R3's hospital admitting diagnosis dated 7/3/22 shows R3 was admitted for traumatic subdural hematoma and scalp lacerations with staples.</p> <p>A Facility Reported Incident-Final, sent to the state agency dated 7/8/22 show that R3 is a 75 year old memory care resident ...alert and oriented x 1, forgetful and confused. R3 has multiple complex medical diagnoses including dialysis MWF ...On 7/2/22 the nurse on duty heard an alarm going off and upon entering [R3's] room, noted resident lying supine (on back) on the floor next to bed with bed on the lowest position. Head to toe assessment was done, noted with bleeding from back of her head. Pressure applied to help stop bleeding ...911 was called ...No loss of consciousness observed. Resident was sent to the hospital via 911. Staff interview and record review were completed. The same report documents that R3 has poor safety awareness, poor insight on current placement and situation and has impulsive behavior contributing to her risk. R3 was admitted to the hospital with diagnosis of subdural hematoma and laceration with metallic skin staples.</p> <p>On 8/12/22 at 10:30 AM, V10 (Registered Nurse) said she was R3's nurse when the incident happened on 7/2/22. V10 said she was at the nurses station when she heard an alarm going off. V10 said she was not sure where the alarm was coming from. V10 said as she was walking in the hallway, she checked the room by the nurses station where she thought the alarm was coming from but the alarm was not coming from the room. V10 said she continued to walk towards the end of the hallway to R3's room, she</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>heard the sound that R3 fell. By the time she got to R3's room, R3 was already on the floor lying on her back. R3's head was bleeding. V10 said she called 911 and notified R3's physician and family. V10 said R3's room was located quite a way from the nurses station and R3 cannot be observed when staff are in the nurses station.</p> <p>On 8/12/22 at 9:18 AM, R3 was in the dialysis unit receiving treatment. When asked how she was doing, R3 just nodded. At 10:45 AM, R3 was in her room in the Memory Care Unit sitting in her wheelchair. R3 was very agitated trying to wheel herself towards the hallway saying, "I am paid, I want to go to the Cafeteria., I want to go to the cafeteria! Help, help I need to go there!" repeatedly. R3's room is located at the back of the right side of the 3rd floor hall near the exit door. R3's room is approximately 4 rooms away from the nurses station. R3's room is not visible from the nurses station. This surveyor walked towards the nurses station to look for staff. V7 (Certified Nursing Assistant-CNA) was at the nurses station. V7 (CNA) said she was not aware that R3 was already back from dialysis. V7 also said R3's room is located far from the nurses station and R3 cannot be observed from the nurses station. V7 said R3 has a tendency to transfer herself unassisted to bed so R3 needs to be supervised and R3 cannot be left in her room by herself. V7 said R3 again had a fall less than a week ago.</p> <p>R3's latest care plan show that R3 is high risk for falls due to cognitive impairment, impaired balance during transition, impulsivity, poor safety awareness and muscle weakness. With intervention to include: "I would like staff to move me close to the nurses station for closer observation."</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>On 8/12/22 at 10:58 AM V3 (Director of Nursing-DON) said R3 is high risk for falls due to history of having multiple falls. R3 is very confused and very hard to redirect. V3 (DON) said R3 was in the hospital from 7/2/22 to 7/14/22 (12 days) in the ICU for treatment of R3's subdural hematoma. V3 said R3 continues to be impulsive. R3 had another fall after coming back from the hospital. V3 said R3's room is near the nurses station now compared to her previous room. V3 said R3's room used to be in the farthest back on 3rd floor. V3 and this surveyor went to 3rd floor to check R3's room location in relation to the nurses station. V3 confirmed to this surveyor that R3's room is located at the right side of the hallway, near the exit door. R3's room is 4 rooms away and cannot be observed/not visible from the nurses station.</p> <p>On 8/12/22 at 12:22 PM, V15 (Nurse Practitioner) said residents who have a history of falls including falls with injury should be placed in a room near the nurses station where staff can supervise the resident more frequently.</p> <p>The facility policy entitled Fall Occurrence dated 5/17/22 show, "It is the policy of the facility to ensure that residents are assessed for risk for falls, that intervention are put in place and intervention are revised and reevaluated as necessary."</p> <p>2. On 8/12/22 at 9:01 AM, R4 was lying in bed with her electronic tablet. R4 was unable to answer questions related to her falling in June 2022. R4 denied having a fall. There was a disconnected alarm on the floor next to R4's bed. R4's bed was not in a high position, but it was not at the lowest level to the floor.</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>On 8/12/22 at 8:45 AM, V12, RN (Registered Nurse) said R4 is a fall risk and she fell two months ago. V12 said R4 does not have alarms initiated for fall prevention.</p> <p>On 8/12/22 at 11:04 Am, V13, CNA (Certified Nursing Assistant) said R4 is a fall risk. V13 said R4 does not have fall interventions in place, she does not have a chair or bed alarm, she does not use a bed near to the floor and there are no mats to place on the floor next to her bed. V13 said after a resident falls, the nurses verbally inform them, or they look at the "Help Book" for newly implemented fall interventions.</p> <p>On 8/12/22 at 11:32 AM, V11, Restorative RN, said she is not the second floor manager, but she acts as a resource and has some managerial duties. V11 said R4 is a fall risk and should have a bed alarm and a chair alarm. V11 said R4 is in their "falling star" program, therefore, R4's bed should be in the lowest position, staff should do frequent rounding on R4 and R4 should have the alarms (bed or chair) in place. V11 said when they implement fall interventions, the interventions are updated every Friday and put in the "CNA Help Book." V11 said R4 had a back injury after a fall.</p> <p>On 8/12/22 at 11:59 AM, V14, Fall Prevention Nurse, said R4 had fallen multiple times at home prior to admission to the facility, therefore, she was a high fall risk upon admssion. V14 said a care plan would need to be initiated with a focus on fall risk for a patient at high risk for falls.</p> <p>On 8/12/22 at 1:04 PM, V16, RN, said the paramedics brought R4 back from the hospital on 6/16/22 and left the bed in high position. V16 said</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>she was R4's nurse when she returned from the hospital on 6/16/22. V16 said R4 tried to get up, and within seven minutes of her return, the CNA found her on the floor. V16 said R4 had fallen previously, went to the hospital, had a lumbar fracture with surgical repair, and then returned to the facility (on 6/16/22). V16 said she assessed R4 after she fell following her return on 6/16/22 and found no visible injury, but R4 complained of more pain at her surgical site and on her knee, therefore, she sent R4 back to the hospital.</p> <p>On 8/12/22 at 1:19 PM, V3, DON, said when transportation brings the resident to their room, the nurse and CNA need to go there to do vital signs and welcome the patient. V3 said it is the nurse's responsibility to make sure the resident has a call light and the bed is in low position.</p> <p>The facility's CNA Help Book includes the following information: Fall Interventions List 8/5/22 shows R4 should have a bed and chair alarm. Falling Star/Frequent Faller List as of 8/5/22 lists R4.</p> <p>R4's Admission Record dated 8/12/22 shows she was initially admitted to the facility on 3/1/22 and her diagnoses include, but are not limited to, Wedge Compression Fracture of the first lumbar vertebra (onset date 6/20/22), low back pain, repeated falls, Unspecified fracture of unspecified lumbar vertebra, fusion of spine, lumbar region (onset date 6/16/22), and history of falling (onset date 3/1/22). R4's Minimum Data Set (MDS) dated 7/8/22, shows she has moderate cognitive impairment and requires extensive assistance with bed mobility, transfers, dressing, and toilet use, and is completely dependent on staff for her personal hygiene. R4's Care Plan, not initiated until 6/21/22, shows she is a high risk for falls and</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>interventions include use of a bed alarm to alert staff when resident attempts to get out of bed unassisted, so staff can assist resident and prevent falls. On 7/2/22 the following intervention was added: chair alarm to alert staff when resident attempts to get out of chair unassisted, so staff can assist resident and prevent falls. R4's care plan includes a focus of impaired cognitive function (initiated 3/8/22).</p> <p>R4's Incident Note dated 6/5/22 at 11:37 AM shows R4's husband went to the hall to summon help. R4 was found lying on the floor on her back with her head towards the foot of the bed and her feet towards the head of the bed. R4 complained of lower back pain, and she was sent to the hospital for evaluation. At 11:21 PM on 6/5/22, R4's Progress Note shows staff spoke with the hospital, and was informed R4 was admitted with a diagnosis of a L1-L2 (lumbar) compression fracture.</p> <p>On 6/16/22 at 11:55 PM, V16, RN, documented R4 was found on the floor by an unnamed CNA. V16 documented that R4 was observed sitting on buttocks on floor and complained about having pain on both knees and at her lower back surgical site. V16 sent R4 back to the hospital. On 6/17/22 at 2:15 AM, R4's Progress note shows she was admitted to the hospital with a diagnosis of spinal fracture. On 6/21/22 at 11:10 PM, R4's Physician Progress Note shows the following:...Admitted to (hospital) on 6/16/22 after a fall from bed the day she was discharged from the hospital where she was from 6/5-6/16 (2022)...This patient is recently status post pedicle screw fixation (a procedure that stabilizes and connects vertebrae in the spine to bone grafts to certain types of spinal surgery. These connections allow the bone grafts to fuse with the existing bone) for compression fractures, burst fracture T12-L3... Within hours of</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>discharge, she had a fall at the nursing home and returned to the hospital...the radiologist notes a transverse process fracture of L3...no further neurosurgical intervention is indicated.</p> <p>R4's Admin Census/Rates document dated 8/12/22 shows she went to the hospital on 6/5/22 and returned to the facility on 6/16/22, then went back to the hospital on 6/16/22 and did not return to the facility again until 6/20/22.</p> <p>R4's Hospital Records from 6/16/22 titled Clinical Discharge Summary show ...Visit Reason- Fall; L1-L2 compression fractures with retropulsion (a retropulsed fragment is any vertebral fracture fragment that is displaced into the spinal canal) ...Encounter diagnoses 1. Hip pain: Retropulsion: Spinal compression fracture ...Procedures: Spine Lumbar Laminectomy (6/15/22) ...</p> <p>R4's Hospital Records from 6/20/22 titled Clinical Discharge Summary show ...Visit Reason- Knee pain-swelling; fracture ...Encounter diagnoses 1. Knee contusion; 2. Fracture of transverse process of lumbar vertebra ...</p> <p>(A)</p>	S9999		