STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014369	A. BUILDING: _____ B. WING _____	C 01/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA WHEELING	730 WEST HINTZ ROAD WHEELING, IL 60090

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S 000	Initial Comments Complaint Investigation:#2119495/IL141613	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 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. These Requirements were not met evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility; failed to provide ongoing supervision and monitoring of cognitively impaired residents considered high risk for falls with history of falls; failed to supervise a resident per facility protocol and resident's plan of care. These failures affected two (R3, R4) of two residents reviewed for supervision/falls. These failures resulted R3 being outside in cold winter temperature unsupervised; R4 had multiple falls with most recent fall resulting in emergent transfer to hospital and stitches to the head as a result of injury. Findings include: 1. R3 is an alert and oriented 70-year-old with diagnoses listed in part with absence of right below-the-knee amputation, peripheral vascular disease, diabetes, and end-stage kidney disease. On 1/22/22 at 9:55 AM, R3 was observed outside the patio adjacent to the facility parking lot facing the main road. R3 had a red waist-length winter coat and was seated in her wheelchair against a patio table. R3 was observed smoking in cold winter temperature that read 18 degrees as it appeared in surveyor's vehicle reading. At 10:45 AM surveyor walked past an empty dining room area and found the exit to where R3 went out to the patio area and found R3 still outside smoking cigarettes. A sign on the door inside the dining room area leading to the patio read, "Patio closed. Door alarmed." There were no staff present to monitor or supervise R3 while she was outside in the freezing temperatures. Surveyor returned back to the main area to look for staff and requested for a supervisor. V4 (nursing supervisor) accompanied surveyor to the	S9999		

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S9999	Continued From page 3 patio area and identified the resident and stated, "That's (R3) she's a smoker but I don't know how she got outside because this door should be locked." V4 was observed pushing the unlocked patio door open with no alarms triggered as shown on the sign the patio was closed and door was alarmed. Surveyor asked about this, V4 stated, "I don't know, this door should be locked and alarmed." Surveyor asked if there were any cameras outside to monitor any residents, V4 stated, "I don't see any but there should be someone with her." Surveyor asked R3 how she was able to go outside, R3 stated, "I always come out here on my own to smoke and the door is never locked." Surveyor asked if staff were to accompany her whenever she goes outside, R3 responded, "I was never told that and there's never anyone that ever accompanies me or even asks me where I'm going." On 1/24/22 at 1:39 PM interview with V4 (RN) stated, "R3 is alert and oriented x 4 she is very "with it". She usually goes out to smoke but there should be someone assigned to supervise her while she is outside smoking. I know the other day there was no one with her but some activity aide or the activity director who was here at the time should have assigned someone to supervise her." Surveyor asked whether R3 was considered a fall risk, V4 stated, "I know she needs assist for transfers from bed to her wheelchair because she is an amputee and she is wheelchair- bound but we never considered her a fall risk." A care plan dated 4/13/21 reads in part (but not limited to), "(R3) requires supervision with walking in corridor, walking in room, locomotion, toilet use, related to: right below knee amputation, low back pain, use of prosthesis.	S9999		

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S9999	Continued From page 4 A fall risk care plan dated 11/18/19 reads in part (but not limited to): (R3) is at risk for falls and related injuries due to: amputation of right leg below the knee, uses prosthesis, diagnosis low back pain, gait and balance impairment." A smoking care plan dated 8/25/20 reads in part (but not limited to): (R3) is a smoker and expresses the desire to smoke at this facility. Interventions: Remind the resident that staff will be observing and supervising smoking-related behavior." 2. R4 is an alert an oriented 78-year-old with diagnoses listed in part with multiple sclerosis, vertigo, encephalopathy, diabetes and hypertension. Care plan dated 10/29/21 reads in part, "(R4)" is at high risk for falls related to: recent fall, current medication use of diuretics, antihypertensives. Poor safety awareness, unsteady gait, disease process (Multiple Sclerosis, unsteadiness on feet, A-Fib., vertigo, anemia, diabetes) and history of falls. Interventions: Bed alarm, Chair alarm, Educated resident to ask for assistance with toileting and self-catheterization setup. Keep call light within reach when in bedroom or bathroom; Use of assistive device during ambulation to prevent falls. On 9/3/21 at 08:45 AM, V14 (LPN) wrote in the progress notes, "Incident Summary: Prior to the incident the nurse on duty went to check the resident's blood sugar at 8:10 AM, the resident was lying in his bed with call light and personal belongings within easy reach. At 845 AM, the assigned aide reported R4 is on the floor. Nurse on duty went to the R4's room	S9999		

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S9999	Continued From page 5 and saw the resident lying on his left side, on the floor, on the left side of his bed with head towards the footboard, side and legs towards the head side. Head to toe assessment done no visible injury noted on his head or any part of the body. R4 denies hitting his head on any hard surface and denies any pain on any part of the body. R4 refused to use mechanical lift, assisted resident back to bed with four person assist. Notified NP with order to initiate neuro check, Left message for doctor." On 10/29/2021 at 2:28 AM V13 (LPN) wrote in progress notes: "Incident Summary: R4 last seen around 1 am sleeping in his bed. Around 1:25 am alarm was sounding from R4's room and resident was noted lying on his right side beside his bed. Head to toe assessment revealed a laceration to the forehead. Moderate bleeding was noted, and pressure was applied to stop bleeding. MD and POA were made aware. R4 was sent to ER via 911 for evaluation." On 11/27/21 at 11:03 AM V14 (LPN) wrote a third incident note that read, "Incident Summary: At 09:30 AM, assigned CNA (certified nurse aide) reported R4 is on the floor. The writer went to the resident's room, saw resident sitting on the floor leaning on his bed and holding the side rail with left hand, wheelchair was behind him. Head to toe assessment done resident denies any pain or discomfort. Resident denies hitting his head on any hard surface. Assisted the resident to his bed with the two persons assist. R4 said, he tried to transfer himself from bed to chair by himself, forgot to lock the wheelchair and sat on the floor. Called the on-call doctor and notified him, he advised to monitor the resident for any symptoms an start Neurocheck, Neurocheck started."	S9999		

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S9999	Continued From page 6 On 1/24/22 at 11:20 AM, Surveyor visited resident in his room and R4 was observed sitting in his wheelchair with his call light that was attached to his bed away from R4's reach. Surveyor asked if he was able to reach his call light, R4 stated "I can't reach it but good luck getting anyone to answer it. They are very short staffed here." Surveyor asked about his falls and most recent fall, R4 stated, "I was catheterizing myself because I could no longer wait for a nurse that night and the next thing I know is I was in the hospital. I had a huge black eye, several stitches to my head, and face and I was in a lot of pain. I fell straight on my face on the hard floor, I must have slipped because of my own urine and I must have hit my face and head pretty hard because I only remember being in the hospital next." Surveyor asked what the nurses were doing to prevent him from falling again, R4 stated, "Well not much because I still have to catheterize myself even after I fell. I know they'll tell you that it's my preference but it really isn't. I'm doing it myself out of sheer frustration with getting anyone to come do it in time." Surveyor asked about the wheelchair alarm that was observed behind his chair, R4 stated, "What's that going to do. It will ring when I'm already on the floor. They also claim to put an alarm on my bed but most the time it doesn't work but just wakes me up when I shift my body. It's also what rang when I was already on the floor unconscious when I remember being in the hospital next. It's another convenience for them, not for me." On 1/24/22 at 11:35 AM interview with V14 (LPN) stated, "Yes I'm (R4)'s nurse today. I take care of him often. He catheterizes himself but we normally don't do that for him. He has all his supplies to do this at bedside. Surveyor asked whether R4 was considered a fall risk, V14	S9999		

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S9999	Continued From page 7 stated, "No he does things by himself and we just watch him a lot." Surveyor asked about the falls R4 sustained, V14 stated, "I'm sorry, I wasn't on duty when he fell." Surveyor clarified whether she was the nurse on duty when R4 fell on 9/3/21 and 11/27/21, V14 replied, "Yes I recall he fell those times." Surveyor asked again whether R4 would be considered a fall risk since falling 3 times, V14 stated, "Yes, I guess he is." Surveyor asked again what she did to prevent R4 from falling and sustaining further injury, V14 stated, "We monitor him often and not just me but everyone that passes by his room should be monitoring him." On 1/24/22 at 2:00 PM, V3 (Assistant director of nursing)ADON stated, "I know (R4) has been self-catheterizing himself for many years and he wants to maintain his independence in doing so." Surveyor asked about R4's lack of safety awareness based on the facility's own assessment, V3 stated, "I see what you mean. The nurses should be present when R4 is self catheterizing himself or assisting him with this for safety reasons and to prevent any further fall incidents. We can reevaluate this later on." Interviews for V5 (former DON), V6 (former staff LPN), V9 (Former maintenance director) could not be conducted as all were no longer employed with the facility. Interviews for V2 (current Director of Nursing)DON, could not be obtained due to being on vacation and V19 (Restorative Director) being on leave for 3 months according to V3 (assistant director of nursing)ADON. On 1/24/22 at 10:35 AM with V12 (Medical	S9999		

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S9999	Continued From page 8 Director) stated, "I am the medical director for this facility. I attended the monthly QA meeting just last month. We always talk about all the falls and injuries that occur in the building and we follow our general policies pertaining to this. From my recollection the facility will conduct a full fall risk assessment upon admission, after an accidental fall occurs or when any injuries occur and are care planned. This is also conducted on a quarterly basis. As a general statement I can give you is that any of these falls will be directed to receive PT (physical therapy) evaluation and also for OT (occupational therapy) evaluations. They also conduct pharmacy review of medications to see if it might cause unsteadiness and requires any changes. Overall, these are my general expectations but otherwise, I don't know if there are a lot of falls but that we do discuss them. " Facility policy dated 7/28/21 titled "Fall Occurrence" reads in part (but not limited to): "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 them from falling. A fall risk assessment from will be completed by the nurse or falls coordinator upon admission, readmission, quarterly, significant change, and annually. 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. The nurse may immediately start interventions to address falls in the unit." " B"	S9999		