Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000889	A. BUILDING: ______ B. WING ______	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA MORTON GROVE	8425 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigations 2292509/IL145252 2292144/IL144768	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)2)3) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies 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. Section 300.1010 Medical Care Policies	S9999	**Attachment A** **Statement of Licensure Violations**	

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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, 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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

2) All treatments and procedures shall be administered as ordered by the physician.

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

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resident's medical record.

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:

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.

Section 300.3240 Abuse and Neglect

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 Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide the necessary physician ordered treatment and services to promote healing of existing pressure ulcers and prevent the further development and worsening of pressure ulcers. This failure affected 3 (R1, R3, R4) reviewed for pressure ulcers; with this failure causing R1 moisture associated skin damage, R3 with worsening sacral stage 4 pressure ulcer, and R4 with a worsening stage 3 left sacral pressure

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ulcer.

Findings include:

1. R1 is a cognitively impaired 83 year old resident with diagnosis, listed in part with chronic obstructive pulmonary disease, malignant neoplasms, diabetes and major depressive disorder.

On 4/11/22 at 11:10 AM, R1 was observed in bed on an air mattress and multiple padding and sheets strewn about her bed. The bed was raised waist high and underneath the bed were two blue boots (heel protectors) that were not applied to R1's feet to protect her ankles. On R1's bedside table was a green triangular and elongated wedge cushion. R1 was asked if anyone came to place the boots on her and about the wedge cushion, R1 stated, "My granddaughter wants those on me, but there's no one here today." Surveyor asked what she meant about no one being here today, R1 stated, "Well I just saw them earlier today and then no more."

On 4/11/22 at 1:34 PM, R1's family stated, "I was visiting my grandmother one day and she was complaining of some pain on her backside, and when we called for help and the aide came to change (R1), I noticed this large open bed sore on her butt. I asked the aide at the time if she ever saw that, and she told me she never did. I was really upset about this, and I complained to the nurse (I cannot recall her name). I don't know why this was never communicated to me at the time. I literally had to ask the nurse to call the doctor, otherwise it did not seem she was even aware of the new wound until I had to say something. I mean, don't they notice this when they bathe her or when they change her diaper?

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That tells me none of these things are happening, and my grandmother is somewhat confused and really can't speak up for herself.

R1's care plan dated 3/28/22 reads in part, "(R1) has potential for pressure injury development or impairment to skin integrity related to generalized weakness, and diabetes. 3/28/22 (R1) is noted with MASD (moisture associated skin damage) on sacrum extending to buttocks. Goal: (R1) will maintain skin integrity. Interventions: Keep skin clean and dry; Skin check every shift during routine care and showers; turn and reposition every 2 hours and as needed and as tolerated."

R1's MDS (minimum data set) assessment dated 1/27/22 shows R1 with no pressure ulcers but, assessed as at-risk for development of pressure ulcers. This same MDS assessment showed R1 on a turning and repositioning program along with pressure reduction mattress for her bed and chair.

A wound assessment dated 3/31/22 written by V14 (wound doctor) reads in part "(R1). Patient presents with a wound on her buttock. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today. (R1) has a wound buttock for at least 1 day duration. Wound size 10 centimeters by 10 centimeters by "not measurable" centimeters depth."

Interview with V10 (wound coordinator) on 4/11/22 at 11:30 AM affirm R1 sustained a pressure ulcer while in the facility on 3/31/22. V10 stated, "R1 had a MASD (moisture associated skin damage). She's incontinent and wears a diaper and she has to be turned and repositioned often. We are treating it now." Surveyor asked

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whether R1's new wound was facility acquired, V10 stated, "Yes it is and it's new."

On 4/11/22, at 3:30 PM, surveyor returned to observe R1 but, instead watched as the resident was being transported out to the hospital. V5 (LPN) was asked about R1's transfer and stated, "We noticed a change in condition with her, so we transferred her to the hospital after I called the doctor." Records show R1 was sent out due to shortness of breath.

2. R3 is an alert and oriented 78- year-old with diagnosis listed in part with Stage 4 pressure ulcer of sacral region, paraplegia, pressure ulcer of left hip, pressure-induced deep tissue damage of right heel and left heel, and neuromuscular dysfunction of the bladder.

MDS (minimum data set) assessment dated 4/22/22 shows R3 requiring extensive assistance with a minimum 2 persons for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.) This same MDS assessment shows R3 as being at high risk for developing pressure ulcers/injuries, and with the facility plan for R3 to have a pressure reduction mattress, pressure ulcer/injury care, and on a turning/repositioning program.

On 4/13/22 at 10:21 AM, V10 (LPN- Licensed Practical Nurse/ Wound Coordinator) was observed outside R3's room. Surveyor asked to observe a wound treatment and inquired as to which resident she was going to do treatment on. V10 stated, "I'm about to do (R3). I'll be back because I have to get something." V10 proceeded to go off the unit and surveyor waited for V10 to return. Surveyor noticed V11

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S9999	Continued From page 6 (LPN/Treatment nurse) already in R3's room, so surveyor entered R3's room and saw that V11 (LPN Treatment nurse) hurriedly trying to do wound treatments on R3's lower extremities. R3 was flat on his back with both legs exposed, and V11 applying treatment ointment on to R3's heels. Surveyor asked V11 to describe the wounds as she was conducting treatment, V11 stated, "I know they are pressure ulcers but, I don't know what kind. I know that both heals are pressure ulcers, and the one on his sacral area is a stage 2." Surveyor asked if she was trained on how to conduct wound care, V11 stated, "Not really. I was a patient care tech in the hospital, and became an LPN and work here now. I usually follow the wound doctor (V14), when she rounds here every Monday." Surveyor asked whether V14 ever described the wounds she was treating for patients in order for her (V11) and other treatment nurses to learn about wounds, V11 stated, "I don't know. I just watch but I don't really listen." V10 (LPN/Wound coordinator) returned and joined V11 (LPN/Treatment nurse) and surveyor who were already in R3's room. V10 stated, "Okay I'm ready to show you the wounds." V10 asked V11 to turn R3 to his side so they could begin treatment on R3's sacral area. V11 turned R3 to his right side and slowly removed and peeled away R3's incontinence brief which was stuck to R3's buttocks. On R3's incontinence brief was a large mound of brown bowel movement that spread in between R3's buttocks, up and around his testicles and penis area. Fecal matter was also present in and around the large open sacral wound that appeared in the size of a soft ball. The sacral wound appeared reddened and inflamed with black areas around its circumference. Surveyor asked whether they	S9999		

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S9999	Continued From page 7 (V10 and V11) asked the nursing aide before starting wound care on their patients, V10 stated, "They are supposed to get them cleaned up first but, I don't know who the aide is today." V10 walked to the door of the room and shouted down the hall to the nurse and asked for an aide to come help. No one came. V10 and V11 ended up cleaning R3 before proceeding with the treatment. Surveyor asked if they knew who the aide that was assigned to care for R3, V10 and V11 stated, "We don't know. It could be agency aide." After cleaning up R3, surveyor asked V11 to describe the wound they were about to treat, V11 stated, "R3's sacral wound is a stage 2." V10 corrected V11 and stated, "No, it's a stage 4." Surveyor asked V10 to describe the wound, V10 stated, "It's a stage 4 to the sacrum measuring about 10 centimeters by 11 centimeters, and 0.5 in depth. It's been stable, and there is no undermining or tunneling. Surveyor asked what the black edges were around the wound, V10 stated, "It's necrotic (dead, nonviable) tissue." Surveyor asked if she was sure there was no undermining of R3's wound as V10 was able to place her fingers under and around the circumference of the wound. V10 stated, "Yes you're right it is undermining. It wasn't there before." Surveyor asked if that is an indication of decline in the wound, V10 stated, "It is." Surveyor asked what the cause could be for the decline, V10 stated, "I don't know." Surveyor asked what preventative measures R3 had to help heal wounds and prevent the formation of other wounds, V10 stated, "They're supposed to be turning and repositioning him at least every 2 hours and keep him clean and dry." Surveyor asked if this is what they observed for R3, V10 stated, "No, it doesn't seem that way. I'll make sure to inform my manager." Surveyor asked again if this could be a reason for the decline in	S9999		

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R3's wound, V10 stated, "I guess so."

At the end of R3's wound observation, surveyor walked over to V12 (RN) who was sitting at the nursing station. Surveyor asked if R3 was her patient and asked about R3. V12 stated, "Yes he's mine. I don't know much about R3, I am only a PRN (as needed) nurse, and this is my first time working on this unit." Surveyor asked who the nursing aide that was assigned to care for R3, V12 stated, "Let me check the schedule. It's V13 (CNA) that's assigned to him, do you want to talk to him?" Surveyor asked how many residents were assigned to her and to V13, V12 stated, "I only have one CNA and there are 19 residents here on this unit." Surveyor asked what kind of residents were on her unit and the type of care they had, V12 stated, "They are mostly heavy care long term residents here." Surveyor asked what she meant by heavy care, V12 stated, "They need maximum assistance to do most things." Surveyor spoke to V13 (CNA) who came walking down the hall and asked about R3. V13 stated when asked, "I changed R3's diaper at around 7:45 AM this morning when I got in." Surveyor asked if he saw him later after that, V13 stated, "No, I was doing other residents."

#3. R4 is a cognitively impaired and developmentally disabled 60-year-old resident with diagnosis listed in part with dysphagia, toxic encephalopathy, celiac disease, and quadriplegia.

R4's care plan dated 3/31/22 reads in part, "(R4) is at risk for additional skin breakdown related to functional quadriplegia, toxic encephalopathy, major depressive disorder. Interventions: Keep skin clean and dry; Off load heels as ordered; Turn and reposition as needed; Wound MD consult."

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S9999	Continued From page 9 R4's MDS (minimum data set) assessment dated 4/6/22 shows R4 requiring total dependence in bed mobility with a minimum of 1-person physical assist to perform this function. This same MDS assessment shows R4 to be at risk for further development of pressure ulcers, and placed on skin and ulcer treatments, and for a pressure reducing device for chair and for bed however, does not place R4 on a turning and repositioning program required to off-load pressure due to her inability to perform bed mobility as R4 is totally dependent to perform this function. On 4/13/22 at 10:55 AM, Surveyor requested V10 (LPN/Wound Coordinator) and V11 (LPN/Treatment nurse) to observe wound treatment for R4. R4 was observed in bed in a fetal position clutching on to a cloth doll. R4 was lying atop an air mattress on her bed. R4's hair was disheveled, matted, and she was dressed in a bluish-gray, and urine stained hospital gown. A feeding pump was heard beeping continuously to the left of R4's bed indicating that pump needed attending to. R4's bed linens were in disarray and crumpled all over and under R4's body. Under R4's upper left shoulder were 2 green incontinence pads that were folded over to create 4 layers. Under R4's buttocks were two more green incontinence pads folded over twice to create 4 layers. A crushed, yellow stained wet pillow was observed directly under R4's buttocks with more linens and sheets that were scrunched up around R4. Surveyor asked V10 about the abundance of linens, V10 stated, "No this isn't right. She should not have all this padding, sheets and linens under her. We've had inservices (training) about this." Surveyor asked the rationale for limited use of padding and sheets, V10 stated, "It defeats the purpose of pressure	S9999		

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reduction when you have all these pads under her." Surveyor noticed a yellow circular stain under R4 where the pillow was removed. Surveyor asked if that was urine, V10 stated, "No it looks like her feeding tube was leaking." Surveyor asked about the linens again and observed V10 turning the air mattress pump on. Surveyor asked if the air mattress was deflated and turned off, V10 stated, "Yes. I don't know why this was turned off. I'll find out from the CNA." At 11:07 AM, V13 (CNA-certified nurses' aide) entered the room and was asked about the air mattress that was turned off and the alarming feeding pump, V13 stated, "I didn't notice any of that when I last saw her." Surveyor asked when the last time he came in to care for R4, V13 stated, "I checked in on her at 7:30 AM." Surveyor asked if he did any incontinence care for R4 when he came in around 7:30 AM, V13 stated, "No, I just checked to see if she was okay. The night shift must have turned off the air mattress this morning and also put all those pads under her because I didn't do that." Surveyor asked if there were any other aides in his section that cared for R4, V13 stated, "No, I'm the only CNA assigned here. There's one other one but she's in the front section in the other unit." "Surveyor asked how many residents he took are of today, V13 stated, "I think I have 17 or 19 or something like that. Surveyor asked whether he turns and repositions residents, V13 stated, "I wasn't told to do that by the nurse." Surveyor asked whether the computer system they use prompts them to turn and reposition residents, V13 stated, "Yes I think so, but we just check that off."

Surveyor asked V10 (Wound coordinator) to proceed with the wound care after R4's incontinence brief was removed. V10 showed surveyor R4's wounds and stated, "She (R4) has

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an unstageable pressure ulcers to her left ischium, left lower buttocks, left sacrum area, and right sacrum area. She also has a DTI (Deep tissue injury) on her right hip with necrosis (dead non-viable tissue) and has a stage 3 pressure ulcer on her right ischium." Surveyor asked whether R4's wounds had shown improvement or worsened, V10 stated, "I can't say. The doctor usually determines that." Surveyor asked whether they used PUSH (Pressure Ulcer Scale for Healing) scores to measure progress in the wounds, V10 stated, "Yes we do but I'd have to check to see what that is and let you know."

Surveyor asked about the mattress pump settings on the bed and asked V10 if there was any inservice training provided to the nurses and nurses' aides about their maintenance and how to make the beds up, V10 stated, "I know that we were all taught to minimize the amount of sheets on the bed." Surveyor asked about the settings on the pump which had an option of static mode to be on or off, V10 stated, "That button should be at off mode. If it's turned on to static-mode that means it is not on alternating pressure. I don't even know why it's turned on or even have that button to begin with."

Records provided to surveyor showed R4's left sacrum wound to have a PUSH score on 3/25/22 to be at a "10" (PUSH scores are from 0 to 17. 0=healed. The higher the number up to 17 means it has worsened).

R4's wound records show measurements of the wound at 1.5 centimeters by 1.0 centimeters and an unknown depth and overall measurement area at 1.5 centimeters.
R4's wound assessment of the left sacrum dated 4/4/22 showed a decline in the wound with a

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PUSH score = "12" and with an increase in size: 2.00 centimeters by 2.00 centimeters x unknown depth and area increasing in size to 4.00 centimeters.
The latest assessment dated 4/11/22 showed a worsened PUSH score of 14 and with an increase in measurement: 3.00 centimeters x 3.00 centimeters by 0.1 centimeters depth and area size of 9.00 centimeters with the wound showing "Erythema" (reddening as result of injury or irritation) and "Maceration" (breaking down of skin resulting from prolonged exposure to moisture). Wound progress: "Deteriorated."

On 4/13/22 at 2:05 PM surveyor interviewed V14 (wound doctor). Surveyor asked whether the nurses she rounds with should be familiar with treatment methods to prevent and treat pressure ulcers, V14 stated, "I found that in the nursing homes I visit and round in, that nurses know nothing about wound care and that's pretty uniform across all the facilities I go into. Surveyor asked during her wound rounds whether specific wound care nurses should be educated and know the rationale for the treatments she orders, V14 stated, "No I wouldn't." Surveyor asked the importance of repositioning residents to off load pressure, V14 stated, "Repositioning is definitely important but if you're referring to (R3), he refuses to be repositioned and the son also requests that (R3) not be turned because he has pain issues. In fact, I have documented that in my wound notes." Surveyor mentioned that wound care was observed with R3 who was not at all resistant to being turned and repositioned during wound care. V14 stated, "Well I just know that he doesn't like that." Surveyor asked whether in general, if turning and repositioning residents were an important factor in preventing and/or healing of wounds, V14 stated, "In general, yes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000889	A. BUILDING: ______ B. WING ______	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA MORTON GROVE	8425 WAUKEGAN ROAD MORTON GROVE, IL 60053

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

it's important to turn and reposition patients as its going to be off-loading to the wound." Surveyor asked about linens and other padding on top of an air mattress, V14 stated, " I ask that blankets and "chucks" (incontinence pads) aren't layered on the bed. I discussed this with staff and not layering of them on the bed. Surveyor asked what the rationale is for not over-layering of linens and pads, V14 stated, "It defeats the purpose of the air mattress and will cause pressure on the skin." Surveyor asked if moisture or wetness on the skin can cause skin damage, V14 stated, "Yes I heard about the pillow underneath (R4). It's meant to be used as a wedge to off-load pressure so I approve of that." Surveyor informed V14 that the pillow observed was immediately under R4 and was observed wet. V14 stated, "Well if it was wet that would definitely not be good as it can cause skin breakdown." Surveyor asked if the alternating mattress on the bed should be placed on a static mode, V14 stated, "I would prefer them to be alternating not static otherwise it's not beneficial. I don't even know why there's even an option to turn it to static mode."

Surveyor asked V10 (Wound Coordinator) a policy for the air mattresses but was not provided one during the survey. V10 stated, "I checked and we don't have one for that just a wound policy."

Policy dated 7/28/21 titled, "Skin Care Treatment Regime" reads in part, "It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate topical treatment for residents with skin breakdown. Charge nurses must document in the nurses's notes and/or the wound report form any skin breakdown upon assessment and identification. Furthermore, topical skin treatment must be obtained from the patient's physician. Routine

Illinois Department of Public Health

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S9999	Continued From page 14 daily wound care treatment/dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician. Residents who are not able to turn and reposition themselves will be turned and repositioned every 2 hours unless specified in the Physician Order Sheet. Residents with Stage III and/or IV pressure ulcer will be placed in specialized air mattresses like low air loss mattress with an incontinent brief if they are incontinent only, incontinence pad which will also act as repositioning aid, and either a flat sheet or a fitted sheet which are all necessary to prevent infection control issue. " (B)	S9999		