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
	IL6014369	A. BUILDING: _____ B. WING _____	C 10/28/2022

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

(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: 2298077/IL152094	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 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. These Requirements were not met evidenced by: Based on observation, interview and record review the facility failed to ensure supervision of residents who had a history of falls. The facility also failed to implement fall interventions for high fall risk residents to prevent fall reoccurrence. The facility also failed to update fall care plans after fall incident to prevent future falls in a timely manner. This deficiency affects 3 of 6 residents (R1, R4 and R5) who are reviewed for fall prevention management in a total sample of 6. This failure resulted R1 sustaining a laceration on right orbital area which required suturing at the hospital. This failure also resulted in R1 sustaining a nondisplaced left nasal bone fracture	S9999		

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S9999	Continued From page 2 and right periorbital hematoma. Findings include: 1. R1 was readmitted on 7/12/22 with diagnosis to include Parkinson's Disease, Unsteadiness on feet, Abnormality of gait and mobility, Abnormal posture, Spondylosis with myelopathy lumbar region, Wedge compression fracture of fourth lumbar vertebra, History of falling, Restless and agitation. R1's initial admission assessment dated 5/19/21 and most recent fall assessment dated 8/30/22 indicated he is at high risk for fall. R1's care plan indicated he is at risk for falls related to poor safety awareness, unsteady gait, history of falls, requires assistance for transfers, incontinent of bowel and bladder, cognitive impairment and medical diagnosis of Parkinson's disease and anxiety disorder. He utilizes a wheelchair as a primary mode of locomotion at this time. He is ambulatory with extensive assistance from the staff using a rolling walker. He has a self-care deficit due to weakness, impaired balance and poor coordination therefore requires assistance with ADLs (bed mobility, transfers, dressing, walking, personal hygiene, bathing and toileting). He has impaired mobility. He has extensive care needs. R1's fall incidents: 6/20/21- Observed fall. Observed resident eating in the dining room when he decided to get up to get more food then lost his balance. 6/28/22- Unwitnessed fall. Heard alarm sounding, observed R1 sitting on the floor in front of his wheelchair in the hallway. R1 was sent to the hospital for evaluation due to anti-coagulant usage. 7/11/22- Unwitnessed fall. Observed R1 lying on the floor on his right side in the dining room. R1 was sent to the hospital for evaluation. 8/30/22- Observed fall with injury.	S9999		

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S9999	Continued From page 3 Observed by another resident, R1 got up from his wheelchair and attempted to walk and fell in the lounge area. Nurse observed R1 lying on the floor on his right side. R1 said that he got up from his wheelchair to walk to the dining room without assistance and lost his balance. R1 sustained laceration to the right eye area. R1 was sent out to the hospital for suturing. R1 returned to the facility with diagnosis of right eye laceration repair, nondisplaced left nasal bone fracture and right periorbital hematoma. Root cause analysis done but fall care plan was not updated. R1's hospital record dated 8/30/22 indicated: Laceration repaired of right orbital area. CT Brain without contrast final result listed in part: Nondisplaced left nasal fracture, right periorbital hematoma. Review R1's facility incident reported to IDPH indicated: On 8/30/22 at 6pm, alarm was sounding and R1 was noted laying on the floor outside of the resident lounge. R1 stated "I got up from my wheelchair to walk to the dining room and fell". Head to toe assessment completed and R1 was noted with laceration to the right eye. Area was cleaned and pressure dressing was immediately applied. Neuro checks initiated. No other injuries noted. Vital signs include: BP 122/68, PR 72, RR 20, T 97.2F, O2 98%. Physician made aware and received orders to send R1 to the hospital for evaluation. Family notified. R1 returned with sutures to the right eye and nasal bone fracture. Care plan reviewed and updated. R1's Physical medicine and rehabilitation progress notes indicated on 8/4/22 documented by V26 Physician Assistant: Plan/recommendation: He is supervision for bed	S9999		

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mobility, supervision for transfers, supervision for ambulation. High fall risk. Fall precaution were reviewed.

On 10/25/22 at 10:27 am, V18 LPN said that she has taken care of R1. He is alert and oriented but forgetful. He has poor safety judgement. He tries to ambulate without his walker. He needs constant supervision. He is at risk for fall. He has unsteady gait. He propels himself on wheelchair. She said that he had fall incident on 8/30/22 during evening shift/dinner time. Review R1's progress notes with V18. He was sent out to the hospital for evaluation due to injury to right eye that need suturing. He returned to the facility.

On 10/25/22 at 4:31 pm, V25 RN said that she is assigned to R1 when he had fall incident on 8/30/22 at 6pm. She said she was busy with passing medication with another resident, when she was called to the lounge area and observed R1 was on the lying on floor on his right side. R1 said that he got up from his wheelchair to walk in the dining room. He sustained laceration to his right eye area. He was sent out to the hospital for suturing and came back. V25 said that R1 is high fall risk and needs supervision. V25 said that she instructed V27 Agency CNA to monitor R1 because he is high risk for fall. V25 said that when she talked to her after R1 was sent to the hospital, V27 told her that she does not know who is R1. V25 told her that she should asked her if she does not know who is R1.

On 10/26/22 at 8:30 am, V27 Agency CNA said that V25 RN did not gave report to her about R1. One of the CNA gave her list of her resident assignment. She does not know that R1 was in her list. She was busy passing tray in the dining room. She did not know that R1 was one of her

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S9999	Continued From page 5 assigned residents not until R1 was transferred to hospital. She said that if they told her that R1 is high risk for fall, she will monitor him and will place him in the dining room to be supervised. On 10/26/22 at 10:03 am V8 Restorative Nurse said she review the incident report and conduct her own fall investigation to determine the reasonable cause of fall/root cause analysis. Fall intervention is updated after the fall to address preventive measures. V8 said that she did the root cause analysis and updated the care plan for R1 when she came back from the hospital on 8/31/22. Showed printed copy of R1's fall care plan that was provided by V2 DON, no new fall intervention was updated. On 10/27/22 at 9:55 am, V2 DON said that if a resident is in the lounge area there should be staff with them to monitor. On 10/27/22 at 2:03 pm, Informed V8 of above interview with V25 RN and V27 Agency CNA. V8 said that if there is an Agency Nurse or Agency CNA, the floor nurse will endorse who are the residents on monitoring for high fall risk and the list is in the communication binder for both nurses and CNAs. V8 said that both agency nurses and CNAs should check the binder if they have assigned residents on high fall risk for monitoring. R1 was on the list for resident monitoring for high fall risk. 2. R4 is re-admitted on 11/25/2019 with diagnosis to include Fibromyalgia, Low back pain, Malignant neoplasm of colon, Type 2 Diabetes Mellitus, Pain in shoulder, right knee and ankle, Spondylosis lumbosacral region, Osteoporosis. R4's care plan indicated: at high risk for falls and related injuries due to history of fall, supervision	S9999		

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cuing with walking, locomotion, transfer, use of diuretics, complaint of pain right knee, fibromyalgia, Chronic Obstructive Pulmonary Disease (COPD), and advance age. Intervention: Staff to encourage supervision during showers. She has Activity of Daily Living (ADL) self-deficit care performance related to lack of coordination, other abnormalities of gait mobility and pain. R4 fall assessment indicated she is at high risk for falls. R4's fall incidents: 9/9/22- fall witnessed by roommate's family member. R4 tripped and fell, hitting her head, sustained laceration to her head. R4 was sent to hospital via 911. MD and family notified. R4 returned to facility with sutures to left eyebrow. 10/22/22- witnessed fall. R4 was observed ambulating from her room to the hallway when she suddenly tripped over her foot causing her fall before the nurse can get to her. R4 was not using assistive device at that time. R4 did not hit her head. R4 said that she was walking, tripped and lost her balance. R4 was sent to hospital for evaluation due to anti-coagulant usage. Root cause analysis done. Care plan was not updated.

On 10/25/22 at 10:42 am, Review 2nd floor endorsement log with V18 LPN, noted R4 is on fall follow up due to fall with left eyebrow laceration. V18 said that R4 is assigned to V20 Agency Nurse. V20 said she does not know who is on fall prevention monitoring or who had recent fall, no one endorsed to her.

On 10/25/22 at 10:47 am, Rounds made with V18 LPN looking for R4. R4 found in shower room taking bath by herself. V18 said that R4 is ambulatory, she goes to the shower and bathroom independently.

On 10/25/22 at 10:59 am, Informed V8

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S9999	Continued From page 7 Restorative Nurse of above observation that R4 was found taking bath in the shower room by herself without supervision. V8 said that staff should supervised her. V8 said that she is not aware R4 is not being supervised during shower. On 10/26/22 at 10:15 am, Review R4's fall incidents with V8 Restorative Nurse. Informed V8 that R4's root cause analysis for fall incident on 10/22/22 was done but care plan was not updated. 3. R5 is re-admitted on 12/6/21 with diagnosis to include Cerebral infarction, Bilateral age-related cataract, History of falling, Stage 3 Chronic kidney disease, Diabetes Mellitus. R5's POS (physician order sheet) indicated: Dycem to wheelchair-check placement every shift for safety. R5's care plan indicated: At risk for falls related to current medications use, poor safety awareness, unsteady gait, Disease process (BPH (Benign Prostatic Hypertrophy), Gout, Anemia, Diabetes, Hypertension) and pain. He is noted with impaired balance and weakness therefore utilizes a wheelchair as a primary mode of locomotion at this time. He is noted with behavior of removing his no skid socks related to he prefers to be barefoot placing him at high risk for fall and or potential for injury. Interventions: Dycem (non-slip mat) to wheelchair. Encourage to wear nonskid socks when up in wheelchair. Encourage not to lay at the edge of the bed for safety. He has self-care ADL deficit due to impaired balance, therefore requires limited assistance with ADL's (bed mobility, transfers, dressing, personal hygiene, bathing and toileting, set up with eating and walking. He has extensive care needs and requires support and services of the LTC setting. R5 fall assessment indicated at high risk for fall. R5's fall incidents: 6/14/22- unwitnessed fall.	S9999		

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Observed leaning on his left side on the floor in his room. R5 said that he slipped and landed on the floor. Sustained small superficial scratch on his left lateral ankle. R5 was sent out to the hospital for evaluation due to anti-coagulant usage. 10/13/22- unwitnessed fall. Observed R5 lying on the floor, face down in front of his locked wheelchair, on the left side of the bed. R5 said he was trying to get back into bed from wheelchair but lost his balance, fell and hit his head. Noted scant left nostril bleeding and controlled. R5 was sent out to the hospital for evaluation.

R5's progress notes indicated PT and OT recommendation after fall by V21 Nurse Practitioner dated 10/14/22 and V22 R5's PCP dated 10/17/22. No follow up documentation nor order made regarding recommendation made.

On 10/25/22 at 12:57 pm, Observed R5 lying in bed, closer to the edge of the bed. Not wearing nonskid socks. Observed towel on the floor on his right side of the bed. R5 said that he placed the towel on the floor because its slippery. R5 said he does not have nonskid socks. R5 said that he goes to the bathroom by himself using his wheelchair. Observed no dycem on his wheelchair. R5 said that the staff does not answer his call light. Showed to V8 Restorative nurse observation made. V8 said R5 has nonskid socks in his bedside drawer. V8 said that the CNA need to apply it. V8 said that R5 needs assistance with putting his nonskid socks.

On 10/26/22 at 11:09 am, Observed R5 sitting at the edge of his bed, having difficulty to put his pants on. He does not wear nonskid socks. He does not have Dycem on his wheelchair. Called V8 Restorative nurse to R5's room and showed observation. V8 assisted R5 to don his pants and

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S9999	Continued From page 9 his nonskid socks. R5 is compliance and allowed V8 to put his socks on. Informed V8 that dycem was not applied to R5's wheelchair since yesterday. V8 said that dycem is place to R5's wheelchair to prevent him from sliding. V8 unable to locate dycem in his room. Facility's policy on Fall occurrence indicates: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place and interventions are re-evaluated and revised as necessary. Procedure: 5. Fall coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. 6. The nurse may start interventions to address falls in the unit, even prior to the Falls coordinator's investigation. 7. Ultimately, the Fall coordinator may change the interventions provided by the nurse if the Fall coordinator's investigation identifies a more appropriate intervention for the individual fall. 8. The Fall coordinator will add the intervention in the resident's care plan. 10. The interventions will be reevaluated and revised as necessary. Facility's policy on Fall prevention Program Guidelines indicates: Fall prevention guidelines shall be implemented to promote safety of all residents in the facility. This program shall measure to determine the individual needs of each resident by assessing the risks for fall and the implementation of evidence-based prevention interventions. Procedure: 2. Safety interventions shall be initiated and implemented for each resident identified at risk for fall.	S9999		

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S9999	Continued From page 10 3. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained. 8. An individualized evidence-based plan of care shall be created to reflect fall prevention interventions which could be put but not limited to: N. consider placing confused resident or difficult to redirect resident by the nurse's station or within eye contact. R. May consider PT/OT evaluation. (B)	S9999		