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 07/29/2023

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 Investigation 2396180/162471 Facility Reported Incident of 7-9-23/IL162048 Facility Reported Incident of 7-9-23/ IL162089	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999		

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S9999	Continued From page 2 that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide supervision to prevent a dependent resident from falling for 1 of 3 residents (R3) reviewed for safety and supervision in the sample of seven. This failure resulted in R3 falling on 7/9/23 in her bathroom and sustaining a displaced intertrochanteric fracture of her right femur which required surgical intervention. The findings include: R3's face sheet showed she was admitted to the facility on 6/13/23 with diagnoses to include bipolar disorder, nontraumatic chronic subdural hemorrhage, anxiety disorder, unsteadiness on feet, abnormalities of gait and mobility, lack of coordination, anemia, end stage renal disease and unspecified falls. R3's facility assessment 6/18/23 documents R3 has severe cognitive impairment, requires extensive assistance of 1-2 staff members for all cares, and has a history of falls. R3's care plan initiated 6/14/23 showed, "[R3] has impaired cognitive function related to traumatic subdural hemorrhage... Interventions... Break tasks into one step at a time. Cue, orient, and supervise her as needed." R3's care plan initiated 6/13/23 documents, "[R3] requires assistance with ADL's (activities of daily living) (bed mobility, transfers, dressing, walking,	S9999		

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S9999	Continued From page 3 personal hygiene, eating, and toileting). ... Admitted [R3] to this facility on 6/13/23 from [acute care hospital] status post fall with left frontal lobe subdural hematoma, had hematoma drained and presents with incision on left frontal lobe... period of forgetfulness, able to follow commands, pleasant and cooperative with care, needs cueing, demonstrations, and encouragement from staff for task... Resident needs extensive assist of 1 staff for ADLs... Interventions... Resident on trial for sensor pad alarm in bed to notify staff when there's an attempt to get out of bed without calling for staff assistance..." R3's care plan initiated 6/14/23 documents, "[R3] is high risk for falls related to anxiety disorder, decline in functional status, impaired balance during transitions, impulsivity, poor safety awareness, fall in the last month and recent fall... Interventions... I have period of forgetfulness. I would like staff to frequently reorient me to my surroundings... " R3's fall investigation dated 7/9/23 documents, "Around 8:20 AM, CNA went to the resident to serve resident breakfast tray. Resident asked CNA to take her to the bathroom to use the toilet. CNA assisted resident on the toilet and gave residents privacy by closing the door partially and placing call light within reach. While CNA was waiting on resident, CNA heard a noise and responded immediately. When the CNA opened the washroom door, CNA observed the resident laying on the floor on the right side facing the door. Nurse on duty was near resident room and also heard the noise and immediately responded... resident displays signs of pain when moving right left..."	S9999		

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S9999	Continued From page 4 R3's acute care hospital documentation operative notes showed R3 was admitted to the acute care hospital on 7/9/23 after she sustained a right hip fracture and underwent a surgical repair of her right hip on 7/10/23. R3's July 2023 Physician Order Sheet documents a 7/17/23 order for "Right Hip- Cleanse with NSS (normal saline solution), pat dry, apply Betadine paint and cover with bordered gauze dressing daily and as needed." On 7/29/23 at 9:56 AM, R3 was lying in bed. R3 was agitated and tearful asking for her husband. On 7/29/23 at 12:59 PM, V10 CNA (Certified Nursing Assistant) said, "If a resident with dementia and confusion needs to go to the bathroom we have to stay with them for their safety." On 7/29/23 at 1:11 PM, V9 CNA said, "It was breakfast time, I took her tray into the room and she was trying to get up and go to the bathroom. She was assisted to the bathroom... she said she wanted privacy. I was in the bedroom, she started screaming like something was wrong. It happened so quick. She was on the toilet saying something in her language and the next she was on the floor. The nurse heard it too and came in." On 7/29/23 at 2:16 PM, V3 (Fall Coordinator) said, "[R3] was admitted to use with a chronic subdural hemorrhage. I looked at the referral and she had lots of falls... very confused and impulsive. If she wants to get up she gets up. She is unsteady. She has poor safety awareness... The CNA took her to the toilet and she insisted on closing the door to the bathroom for privacy. The CNA didn't close the door all the way because	S9999		

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S9999	Continued From page 5 she knew she was impulsive. She gave her the call light. [R3] can sometimes use the call light." The facility's policy and procedure revised 5/17/23 titled Fall Occurrence showed, "... Policy Statement, 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 reevaluated and revised as necessary..." (A)	S9999		