STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013098	A. BUILDING: _____ B. WING _____	C 03/06/2023

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BELLA TERRA ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

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S 000	Initial Comments Complaint Investigation: 2371649/IL156896	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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 Regulations are not met as evidenced by: Based on interview and record review the facility failed to safely transfer a resident who was identified as needing two staff assistance. This applies to 1 of 3 residents (R2) reviewed for fall incidents in the sample of 6. This failure resulted in one staff attempting to transfer R2 from bed to wheelchair and in the process R2 buckling her knees requiring the staff to lower R2 on her knees, to the floor. R2 was sent to the hospital and was diagnosed with closed subcapital fracture of the left femur and dislocation of the left knee. The findings include: R2 was admitted to the facility on November 28, 2022. R2 had multiple diagnoses which included dementia without behavioral disturbance and morbid (severe) obesity due to excess calories,	S9999		

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S9999	Continued From page 2 based on the face sheet. R2's admission MDS (minimum data set) dated November 29, 2022, showed that the resident was moderately impaired with cognition and required extensive assistance from the staff with regards to bed mobility, dressing, toilet use and personal hygiene. R2's MDS showed that transfer activity only occurred once or twice with one staff physical assist. The MDS also showed that R2 was not steady and required staff assistance for stability during surface-to-surface transfer (transfer between bed and chair or wheelchair). The same MDS showed that R2 uses a wheelchair as mobility device. R2's documented weight on February 1, 2023, was 218 pounds with the height of 61.0 inches. R2's progress notes dated February 15, 2023 (9:46 AM) created by V5 (agency Nurse) showed, "Resident was lowered to the floor during a transfer from bed to wheelchair. She was unable to stand and pivot and her knees began to buckle under. C/o [complained of] pain noted to bilateral knees after resident was put back to bed. New orders for X-Ray of bilateral knees and volteran gel to both shoulders twice daily." R2's progress notes dated February 15, 2023 (3:37 PM) created by V14 (Nurse Practitioner) showed in-part, "Patient is seen per staff request for a fall this morning. Staff reports that the patient was eased to the floor when she was about to fall. Patient reports that her knees gave away and she fell. She reports much pain to [bilateral] knees. Patient has h/o [history of] knee pain and shoulder pain. Restorative care staff with patient. Patient is in bed, no bruises on knees, has some swelling, had some swelling in	S9999		

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the past too. Patient calm and cooperative, denies chest pain, SOB [shortness of breath], headache, dizziness, abdominal pain, n/v/d [nausea/vomiting/diarrhea]. Still has some pain to shoulders too, which was also there before the fall." The progress notes showed, "pain level: 10." The same progress notes showed under assessment/plan, "[Bilateral knee pain, [status post] fall today. [Continue] Tramadol 50 mg PO [orally] q8h [every 8 hours], [continue] Lidocaine patch 5% to [bilateral knees daily, x-ray [bilateral knees, Call MD (Medical Doctor) with x-ray results."

R2's progress notes dated February 16, 2023 (7:09 PM) showed in-part, "Resident transferred to [hospital emergency room] per PCP (primary care physician) order due to fall last night and inability to have x-ray done to left knee."

R2's progress notes dated February 17, 2023 (1:36 AM) showed that the resident was admitted to the hospital with diagnoses of closed subcapital fracture of the left femur and dislocation of the left knee.

R2's fall incident report dated February 15, 2023 (9:30 AM) showed, "During transfer from bed to wheelchair, this resident was unable to pivot, and the CNA (Certified Nursing Assistant) could no longer support her, so she lowered her to the floor. Resident knees buckled." The incident report showed no visible injuries were observed post fall incident, however R2 complained of pain, with pain level of "10."

R2's fall investigation made by the facility after the resident's fall on February 15, 2023, at 9:30 AM showed under the root cause analysis, "[R2] is alert and oriented x 3 and requires extensive

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assist x 1 person with ADL's (activities of daily living). On [February 15, 2023] resident was eased to the floor by the CNA upon transfer. CNA was interviewed and she reported that she assisted [R2] to the edge of the bed in a sitting position, then assisted her in a standing position to get in the chair, the resident knees buckled, and she assisted her to the floor. Nurse on duty and NP (Nurse Practitioner) were notified. Resident was assessed with no apparent injury noted at the time of the fall. Bilateral knee x-ray was ordered. While waiting for the x-ray to be performed; resident complained of increased pain, MD (Medical Doctor) was notified and ordered to send resident to [hospital] ER (emergency room) for further diagnostic testing where she was admitted with diagnosis of closed subcapital fracture of left femur and dislocation of left knee. Based on investigation, it was concluded that [R2] knees buckled while standing caused her to lose her balance and fell."

On March 3, 2023, at 3:52 PM, V13 (Physical Therapist/Rehab Manager) stated that based on R2's PT (physical therapy) records, R2 was evaluated by the therapist on November 29, 2022. V13 stated that R2 presented with status post fall with diagnosis of right shoulder dislocation and pneumonia. R2 was referred to PT due to decline in her ADL (activities of daily) and non-weight bearing on her right upper extremity. According to V13, based on R2's evaluation on November 29, 2022, the resident was maximum assistance (requiring 75% help) with bed mobility, transfers from bed to chair and sit to stand. R2 was totally dependent (100% help) with toilet transfer, was non-ambulatory, was not able to do wheelchair mobility, was non-weight bearing on her right upper extremity and with decreased sitting balance, which meant

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that the resident was unstable when sitting on the edge of the bed. V13 stated that she compared R2's documented status from the evaluation date and the PT discharge notes dated January 16, 2023, and it showed that the resident had minimal improvement only with regards to transfers from bed to chair, while the rest of the ADL mentioned above remained the same. According to V13, based on the PT discharge notes, R2's transfers from bed to chair minimally improved from maximum assistance to moderate/maximum assistance due to non-weight bearing on the right upper extremity, persistent weakness and obesity. V13 stated that based on R2's discharge status from PT on January 16, 2023, the resident would require two staff assistance with use of a gait belt to safely transfer R2 and to prevent potential fall. V13 elaborated that to safely transfer R2 in the nursing unit, two staff should be assisting the resident, one on each side, both holding the gait belt (at the back side) and the staff positioned on the left side should hold R2's left arm for support. V13 added that since R2 was non-weight bearing on the right arm, the staff positioned on the right side of the resident cannot support/ hold that arm of R2. V13 stated that after R2 was discharged from PT, the nursing restorative nurse was given the status information of the resident. This status information included instructions of what device to use during R2's transfers and how many staff should assist the resident during transfer in the nursing unit. V13 further stated that it is the standard of practice that if a resident needs more than minimum assistance with transfer while in therapy, the resident would require two staff assistance with transfer in the nursing unit, adding the fact that a resident is morbidly obese, it is more important to transfer the resident with two staff assistance with the use of a gait belt for safety. During the same

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interview V13 stated that because of R2's obesity and the buckling of the resident's knees during the incident (February 15, 2023), it was possible that the resident twisted her left knee at some point that caused the closed subcapital fracture of the left femur and dislocation of left knee.

On March 3, 2023, at 5:11 PM, V3 (agency CNA (Certified Nursing Assistant)) stated that she was the only staff assisting R2 on February 15, 2023, when the resident had the incident. According to V3, it was her first time being assigned to take care of R2 on February 15, 2023. V3 stated that prior to her attempting to transfer R2 on February 15, 2023, between 9:00 AM and 9:30 AM, she asked V5 (agency Nurse) how many staff assistance does R2 needed during transfer. V5 told her (V3) that R2 needed only one staff assistance with gait belt. V3 stated that she proceeded to provide care for R2 and attempted to transfer the resident from bed to wheelchair on her own. According to V3 she applied the gait belt on R2's waist area, assisted R2 to sit on the edge of the bed, assisted R2 to stand up and attempted to assist R2 to walk towards the wheelchair. During the mentioned procedure, V3 cannot remember on which side of the resident she was positioned but stated that during the said process she was holding R2's gait belt at the back area and guiding the resident. V3 stated that R2 only took one step towards the wheelchair from the bed area when the resident said, "wait I can't do it." During that time V3 stated that she positioned herself in-front of R2 while holding the gait belt on the front side of the resident. It was during that time that she noticed that R2's bilateral knees buckled, so she lowered the resident to the floor while holding the gait belt on the front side of the resident. According to V3 the incident happened so fast and because R2

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was heavy and her (R2) knees had buckled, when she lowered R2 to the floor, the resident was on a kneeling position. V3 stated that when R2 was on the floor in a kneeling position she called V5 for assistance. After V5 saw R2 on the floor, they (V3 and V5) repositioned R2 from kneeling position to a sitting position on the floor. While R2 was in the sitting position on the floor, V5 assessed R2. V3 stated that after V5 had assessed R2, another CNA came in the room, and they placed R2 in bed using the full body mechanical lift. During the same interview, V3 stated that after the incident with R2, V2 (Director of Nursing) showed her a binder containing all of the residents transfer assistance. V2 pointed to her (V3) that based on the transfer assistance information (inside the binder), R2 should be transferred with the assistance of two staff using a gait belt. According to V3, she was not aware of the said binder, that is why she asked V5 prior to assisting R2.

On March 4, 2023, at 9:10 AM, V5 (agency Nurse) stated that she was the assigned nurse for R2 on February 15, 2023 when the resident had the incident, and it was only her second time taking care of R2. V5 stated that she had worked on February 14, 2023 and was the assigned nurse for R2. According to V5 she was informed by a nursing staff (does not remember the name) during endorsement on February 14, 2023, that R2 is a one staff transfer with gait belt, so when V3 (agency CNA) asked her on February 15, 2023, about the transfer status of R2, she told V3 that the resident only needed one staff assistance using a gait belt. V5 admitted that she did not look at the binder containing each resident's transfer status which was available in the unit, to verify R2's transfer status before telling V3 on February 15, 2023. According to V5, when she

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S9999	Continued From page 8 was called by V3 to R2's room on February 15, 2023, around 9:30 AM, she saw R2 on the floor, about a step or two away from the bed. V5 described R2's position on the floor as, "she was on a twisted position not fully sitting on the floor due to her weight but was partially kneeling on the floor. Her right knee was touching the floor, while her left knee was partially touching the floor. She had a gait belt around her waist." According to V5, R2 verbalized that she was okay and because of R2's uncomfortable position, they (V5 and V3) assisted the resident into a sitting position and had R2 extend her bilateral legs forward. V5 stated that during her assessment of R2, no visible injuries such as redness, bruising, swelling, rotation, or warmth were noted on the resident's legs and knees. R2 also did not complain of any pain at the time. After assessment, V5 stated that they (V5, V3 and another CNA who she does not remember the name) assisted R2 to the bed using the full body mechanical lift. According to V5, after transferring R2 in bed, the resident complained of bilateral knee pain and at that time R2 had pain patches on her knees. V5 stated that because the Nurse Practitioner was in the building, R2 was immediately seen with orders for voltaren gel (topical pain relief) to both shoulders and x-ray of the bilateral knees. On March 4, 2023, at 10:02 AM, V6 (Restorative Nurse) stated that after R2 was discharged from physical therapy she was informed by the therapist that two nursing staff should assist R2 during transfers with the use of a gait belt to ensure safety, prevent fall and prevent injury. V6 stated that R2's transfer status information requiring two staff assistance with gait belt was placed in a binder along with the other residents transfer status, which is available in the nursing	S9999		

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S9999	Continued From page 9 unit. According to V6, she updates the transfer status information every week to reflect any changes. V6 presented the transfer status information forms dated February 9 and February 15, 2023, which showed the transfer status of multiple residents including R2. The same transfer status information forms showed under transfer type for R2, "2-Person Gait Belt." On March 6, 2023, at 1:28 PM, V14 (Nurse Practitioner) stated that she expects the nursing staff to follow the transfer status information during transfer of any resident. According to V14, if the facility had assessed R2 to be needing two staff assistance during transfer with the use of a gait belt, it should be followed for safety and to prevent fall incidents. (A)	S9999		