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 02/11/2023

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 Facility Reported Incident of 12/7/22/IL155034	S 000		
S9999	Final Observations Statement of Licensue Violations 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure adequate supervision is provided to one resident (R1) who is at risk for falls and has had history of multiple falls in the past out of 3 residents reviewed for supervision. This failure resulted to R1 sustaining laceration on right forehead which required sutures and resulted to subarachnoid hemorrhage, displaced fracture right zygomatic arch, fracture of the right inferior orbital wall, fracture of the right superior orbital wall and fracture of the right frontal sinus.

R1 was admitted to the facility on 6/17/2021. R1's Minimum Data Set with a Target date of 12/28/2022 under Brief Interview for Mental Status documents a score of 3/15 which indicates cognitive impairment.

R1's Progress notes dated 12/7/22 documents in part: "At around 7:15 PM, Resident fell in the dining room, was found on the floor of the dinning (sic) room in the prone position, He was assessed for injuries, bleeding on face was noted with a 3 cm deep cut on R eyebrow, ice pack and sterile gauze were applied on wound site until bleeding stopped. 911 called at 7:18 PM, and resident has been transported to xxx hospital at 7:30 pm."

R1's Fall Risk Assessment dated 8/29/22 documents a score of 14 which indicates that R1 is a high fall risk.

R1's Fall List documents that R1 had a fall incident on the following dates: 12/7/22, 8/29/22,

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S9999	Continued From page 2	S9999		

and 6/17/22 within the last 6-8 months.

R1's Fall Care Plan with 12/7/22 revision date documents in part:
R1 is at high risk for falls related to: recent fall, Cognitive impairment, Anxiety, Anemia, History of falling, Altered mental status, Left hemi post subdural hemorrhage, Dementia, anemia, cardiac dysrhythmias, CHF, anxiety, depression, schizophrenia, violent behavior, current medication orders for antipsychotics and antidepressants, and incontinence. Due to R1's diagnosis of psychosis, he is noted with periods of agitation and delusional thoughts placing him at high risk for fall/injury. R1 is noted with increase anxious behaviors placing him at risk for fall/injury.

Hospital records document result of CT of the brain under Findings in part as: There is a small amount of subarachnoid hemorrhage and intraparenchymal hemorrhage in the right anteroinferior frontal lobe. CT of the facial bones under Findings also document: There is a dispalced fracture of the right zygomatic arch. There is a fracture of the right inferior orbital wall without herniation of the intraorbital contents. There is also a fracture of the right superior orbital wall that extends to involve the frontal sinus. The inner table of the right frontal sinus is fractured and there is pneumocephalus. R1 also had laceration of the right forehead which was sutured in the Emergency Room.

On 2/10/22 at 11:17 AM, R1 observed sleeping in bed, bed on low position, with bed alarm, landing pads on both sides of the bed, white noise player on. R1's wheelchair was observed with bolsters on both hand rails. When asked if he recalls his fall incident on 12/7/22, R1 did not respond.

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S9999	Continued From page 3	S9999		

Further questioning still did not yield any response from R1. R1 was murmuring something unintelligible. When asked if he is in any pain, R1 did not respond.

On 2/10/22 at 12:45 PM, V13, Certified Nursing Assistant/CNA, assigned to R1 at the time of the fall stated, "I was the CNA assigned to R1 that shift. Dinner usually starts around 6:00 PM. I fed R1 his dinner, R1 is a feeder. R1 ate everything. I was cleaning up the dining room so R1 stayed in the dining room. There were other residents in the dining room. At that time, I don't really know who was watching the residents in the dining room. Usually one of us is usually there. I can't remember who was in charge of supervising the residents in the dining room at that time. R1 is high risk for falls. R1 shouldn't be left in the dining room unsupervised. I was in and out of the dining room. I did not witness R1 falling. The last time I saw R1 was around 7 PM and then I proceeded to pick up the trays from the other residents' rooms."

On 2/10/22 at 12:05 PM, V12, Restorative Nurse stated, " I am in charge of investigating fall incidents and updating care plans. For R1, based on my investigation, his fall could be more because of his diagnosis or his behaviors that contributed to him falling. R's fall occurred in the dining room around 7:30 PM. We did put R1 on behavior monitoring when he returned from the hospital. V13 was the CNA in charge of R1 at that time. The CNA said that she put R1 in the dining room around dinner time which would have been around 6 PM. The CNA was there when it happened. She didn't witness the fall because she was putting trays away. For R1 if he is calm, he usually stays in the dining room after dinner. When there's people in the dining room, there

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S9999	Continued From page 4	S9999		

should be a staff member supervising the residents. My root cause analysis showed that his behavior contributed to the fall occurrence. On the behavior monitoring for 3 days, I didn't observe any new behaviors that might have contributed to that fall."

On 02/10/2023 at 1:38 PM, V11, R1's Physician when asked if she was informed about R1's fall incident on 12/7/22 stated, "I'm sure I was informed about R1's fall incident. During my last assessment with R1, all I remember was that the patient was in a wheelchair and he was trying to get up and he was sliding from his chair constantly. And you cannot talk to him, about the dangers, about his surroundings. I tried to call the CNA to pull him back up on the chair. R1 was doing it constantly. You cannot keep patient in bed all the time. I think he (R1) will benefit from social interaction and activities. When he (R1) was on the chair, he (R1) constantly gets up. He (R1) is calmer when he is in bed. When he (R1) is in the chair, he needs constant supervision. In his wheelchair, he (R1) probable needs 1:1. I am told there is always somebody sitting there in the dining room. When I visit the facility, I usually see the breakfast service. During meal time, there's always somebody in the dining based on my observation. I am usually there during breakfast, there is always at least 4 staff members in the dining room. I don't know how can R1 be left unattended. But I am not there during dinner time."

On 2/10/22 at 2:02 PM, V7, Licensed Practical Nurse/LPN stated, "I was the nurse assigned to R1 on 12/7. R1 was in the dining room when he fell. I was passing medications and then I was told by one of the nurses that R1 had a fall. R1 was bleeding, we put ice pack on him and I went

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S9999	Continued From page 5 and called 911. R1 got admitted with Subarachnoid hemorrhage. R1 usually eats dinner in bed, most of the time he eats in bed but that day he ate in the dining room. The incident happened after dinner. There's always somebody in the dining room to watch the residents in the dining room. I did not witness the fall." When asked why that day R1 ate dinner in the dining room, V7 responded, "I don't know but when the assigned CNA asked me if R1 should get up and go to the dining room for dinner, I told the CNA to get him up." On 2/10/22, during interviews, V5, V8 and V9, CNA's who worked on 12/27/22 3-11 shift, all denied they were assigned to supervise R1 while he was in the dining room. V5, V8 and V9 all stated that were not assigned to supervise the residents who were still in the dining room after dinner time. On 2/10/22 at 2:21 PM, V10, Certified Nursing Assistant/CNA stated, "When R1 fell, I was in the dining room but I was asking another resident if she wants to go back to bed. No I was not assigned to supervise in the dining room after dinner, I had already watched the dining room before that time, I don't know who was assigned to watch the dining room at time. It wasn't me who was assigned to watch the dining room, I had already watched the dining room earlier." Surveyor told V10 that on the 12/27/22 Assignment Sheet which the facility provided to me, her name was listed as the CNA in charge of watching the dining room from 7-7:30 PM, which was the time R1 fell. V10 stated, "Yes, I was in the dining room but like I said I was there but I was talking to another resident and by the time I turned around R1 was already on the floor."	S9999		

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S9999	Continued From page 6 (A)	S9999		