IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 20, 2019

Illinois Corporation Service C, Registered Agent
Morton Grove Living & Rehab Center, LLC
801 Adali Stevenson Drive
Springfield, Illinois 62703

RE: Complaint #: IL00107668
Survey Date: January 28, 2019
Docket #: 19-C0083
Violation Type: Level B

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Bella Terra Morton Grove.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Bella Terra Morton Grove/January 28, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. MORTON GROVE LIVING & REHAB CENTER, LLC, D/B/A, BELLA TERRA MORTON GROVE, Respondent.	))))))))	Docket No. NH19-C0083

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00107668 Investigation conducted by the Department on January 28, 2019, at Bella Terra Morton Grove, 8425 Waukegan Road, Morton Grove, Illinois 60053. On March 18, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.

3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210a), 300.1210b)3), 300.1210d)2)3), 300.3220f) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 20th day of March, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. MORTON GROVE LIVING & REHAB CENTER, LLC, D/B/A, BELLA TERRA MORTON GROVE, Respondent.	)	Docket No. NH 19-C0083

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Illinois Corporation Service C
Licensee Info:	Morton Grove Living & Rehab Center, LLC
Address:	801 Adali Stevenson Drive Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 20th day of March, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

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 01/28/2019

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 Survey 1897763/IL107668	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1010h) 300.1210a) 300.1210b)3) 300.1210d)2)3) 300.3220f) 300.3240a) 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 300.1010 Medical Care Policies 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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

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 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:

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S9999	Continued From page 2	S9999		

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

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:

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 resident's medical record.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

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S9999	Continued From page 3	S9999		

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview and record review, the facility failed to follow physician orders and monitor urine output when an indwelling urinary catheter was discontinued, failed to recognize signs and symptoms of urinary retention, also failed to follow up with a urologist consult as ordered, failed to ensure that an indwelling urinary catheter was assessed for placement and failed to care plan urinary issues/use of an indwelling urinary catheter which affected one resident (R1) of three residents reviewed for indwelling urinary catheters. These failures resulted in R1's transfer to a local hospital twice with large amounts of bloody urine output, 1600 cubic centimeters (cc) on 9/27/18 with a diagnosis of Obstructive Uropathy and 3000 cc on 10/31/18 and a diagnosis of Acute Kidney Injury.

Findings include:

R1's Admission Record documents the following medical diagnosis: Gross Hematuria, Acute Kidney Failure and Obstructive and Reflux Uropathy. R1 was admitted to the facility on 9/19/18.

R1's Progress Note which was dated 9/20/18 and authored by V17 (APN-Advanced Practitioner Nurse) documents, in part: "On 8/09 patient pulled out indwelling catheter causing hematuria. Urology was consulted. CBI (continuous bladder irrigation) performed and resolved. (Indwelling urinary catheter) re-inserted." R1's medical record indicates that he was admitted to the facility with an indwelling urinary catheter. This note also

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S9999	Continued From page 4	S9999		

documents: "Urinary retention with hematuria. (Indwelling urinary catheter). Voiding trials when appropriate."

On 1/24/19, V2 (Director of Nursing) confirmed that R1 had a diagnosis of Urinary Retention which is justification for retaining the urinary catheter.
On 1/28/19 at 12:30pm, V25 (Nurse Practitioner, Urology) indicated that Urinary Retention would be a reason to keep an indwelling urinary catheter.

R1's Order Recap Report documents a physician order dated 9/24/18 to discontinue R1's indwelling urinary catheter. On 1/28/19, V2 (DON-Director of Nursing) confirmed that 9/24/18 was the date R1's urinary catheter was discontinued. V2 also confirmed that there is no documentation in R1's medical record regarding R1's voiding trial, PVR (post void residual) results, bladder scans and assessment of bladder progress after the catheter was discontinued.

On 1/24/19 at 3:40pm, V18 (Nurse Supervisor) stated, "Voiding trial is for three days on every shift after the (urinary catheter) is pulled out. I got a parameter for him. Bladder scan is done after they urinate. Look for signs and symptoms of difficulty urinating, like distended abdomen." V18 indicated that when an order is entered for discontinuation of urinary catheter then a batch order is generated which includes PVR and bladder scans. V18 confirmed that there was no batch order for bladder scans and PVR's to be performed for R1 after the indwelling catheter was discontinued. V18 indicated that the nurses would not receive notification to do bladder scans and monitor PVR's.
R1's Physician Order Sheet (POS) documents

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S9999	Continued From page 5	S9999		

that R1 was receiving a diuretic twice a day - Furosemide 20 mg (milligrams).

On 1/28/19, V2 stated that after removal of indwelling urinary catheter, "If the post void residual is greater than 350 cc in the bladder, the nurse should straight cath(eterize)." V2 indicated that the purpose of the PVR is to see how much urine the bladder is retaining. V2 indicated that the bladder scan and PVR's are a part of nursing standards of practice. V2 stated, "Only the CNA's (Certified Nurse Assistants) were charting that (R1) was voiding." R1's Bladder Continence record dated 9/24 - 9/26 denotes that R1's urinary episodes were not closely monitored. There is no charting for any night shifts from 9/24 to 9/26 and for evening shift on 9/25 regarding R1's number of urinary episodes. This documentation was confirmed with V2 on 1/28/19 at 3:05pm.
On 9/26/18, R1's Physician Order Sheet documents an order for bladder scan one time only for pain for one day - Bladder scan every shift if PVR above 300 may straight cath. There is no documentation that V19's (Physician) order was followed.

On 9/27/18 at 3:47am, V20 (LPN-Licensed Practical Nurse) documented: "Noted with minimal bleeding from penis, perineal care provided." V20 continues to document that vital signs are stable. There is no documentation that indicates that V20 monitored R1's change in condition or that R1's vital signs were monitored. On 9/27/18 at 7:02am, V20 documents that the bleeding stopped. V20 did not notify V19 regarding R1's change in condition. V20 did not recognize that bleeding from the penis could be a sign of difficulty urinating. It is not documented that R1's bladder was assessed.
On 1/24/19 at 11:17am, V21 (RN-Registered

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S9999	Continued From page 6	S9999		

Nurse) indicated that she was the day shift nurse on 9/27/18. V21 stated, "(R1) was changed by night shift at 6:30am. They told me that he had been bleeding from penis. They told me minimal. I saw the CNA from night shift was gathering towels and it was more than minimal. (R1's) diaper was completely saturated with blood. His baseline is to be very responsive. He was lethargic. Pale. Called (V19) as soon as possible."
V15 (LPN) and V21 (RN) both indicated that they do not know the facility protocol regarding voiding trials. On 1/23/19 at 11:43am, V3 (ADON-Assistant Director of Nursing) stated that the facility does not have a policy regarding voiding trials.

R1's progress notes document that R1 was transported out of the facility at 9:00am and was admitted to a local hospital on 9/27/18 with a diagnosis of hematuria (blood in urine). R1's Emergency Room documentation dated 9/27/18 at 11:16am states that an indwelling urinary catheter was inserted without difficulty. RESULT: 1600 cc of grossly bloody urine. A CT (Computerized Tomography) scan of Abdomen and Pelvis was performed. IMPRESSION: 1) Right renal calculi with no obvious obstruction. 2) Enlarged prostate gland. The urology consultation note documents that R1 stated he felt better after urinary catheter was inserted.

On 1/23/19 at 5:03pm, V22 (Nurse Practitioner) indicated that she was not told specifically about R1 having blood in urine. V22 indicated that there should be more strict intake and output monitoring for residents with diuretics, CHF (Congestive Heart Failure), IV's (intravenous), indwelling urinary catheters and urinary retention. When V22 was asked if residents with urinary

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S9999	Continued From page 7	S9999		

issues should be assessed closely when urinary catheters are discontinued, V22 stated, "I agree, should be monitored closely." V22 indicated that there is a potential for retaining urine when urinary catheters are discontinued and when the resident has prostate issues.

On 10/2/18, R1 was readmitted to the facility with a diagnosis of Obstructive Uropathy with an order to follow up with a urologist for urinary retention. This order also reads: 1 week void trial with PVR monitoring (10/9/18). The hospital urology consult note documents that R1 stated that he had a urologist at another local hospital. There no documentation that the facility followed the orders and arranged for a urology follow up with R1's urologist. There is no documentation that R1's urinary catheter was discontinued and a voiding trial was performed.
On 1/28/19 at 10:59am, V23 (Unit Secretary) indicated that she is in charge of scheduling appointments. V23 indicated that she could not find a urologist that would come and see R1. V23 did not contact R1's urologist. V23 stated, "We did ask several urologists. I didn't document any of the urologists that I tried to call. I get facesheet and go through Google and try to find a urologist like that, that's close to this area. "
On 1/28/19 at 11:06am, V26 (Receptionist for V27 (Urologist) confirmed that the facility did not attempt to make a follow up appointment with V27.

R1's urinary issues and use of an indwelling urinary catheter are not care planned. This was confirmed with V2 on 1/23/19.

R1's Progress Notes document that beginning on 10/27/18, R1 began to complain of abdominal pain. On 10/24/18, R1 had a KUB (kidney, ureter,

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S9999	Continued From page 8	S9999		

bladder) exam that revealed constipation. R1's progress notes indicate that issue was resolved on 10/25/18. It is also documented that R1 was having bowel movements (bm) daily. On 10/27/18, R1's abdomen was hard to touch. Stool softeners were given and R1 had a bm. It is not documented that R1's urinary catheter was assessed. It is documented that R1 had a medium bm on 10/28. On 10/30/18 at 11:02pm, R1 complained of abdominal pain and again R1 was given stool softeners. It is documented that R1 was observed with blood in catheter bag and that R1 was seen pulling on his urinary catheter. On 10/31/18 at 12:06am, there was sediment noted in the urinary bag. There is no documentation that indicates R1's physician was called regarding the sediment in the urinary bag. At 2:15am, R1 was found unresponsive and transferred to a local hospital with the diagnosis of Acute Renal Failure, Hyperkalemia and hypotension.
R1's hospital records documented that R1's indwelling urinary catheter was exchanged with an immediate result of 3000 cc (3 liters) of bloody urine. The urology consultation note dated 10/31/18 documents an impression: Malfunctioning (indwelling urinary catheter).

During interviews, V2 (DON), V15 (LPN), V18 (Nurse Supervisor), V21 (RN), V24 (Nurse Practitioner) and V25 (Nurse Practitioner, Urology) all indicated that abdominal distention can mean that the resident is experiencing urine retention. There is no indication in the documentation that R1's urinary catheter was assessed for placement despite R1's behavior of pulling at the urinary catheter.

On 1/28/19 at 12:30pm, V25 (Nurse Practitioner, Urology) confirmed that their urology service saw

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(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 9	S9999		

R1 in the emergency room in September 2018. V25 stated, "Part of voiding trial protocol is to check post void residual to make sure they're emptying their bladder appropriately. With BPH (benign prostatic hypertrophy), the risk is high of retaining urine. PVR done after a patient urinates. Chronic (indwelling urinary catheter) should not have urinary retention. In theory should not have urine sitting in bladder because urine is constantly draining. Should not have urinary retention. When (indwelling urinary catheter) is discontinued, bleeding could be a sign of difficulty urinating. A urologist should see a resident with obstructive uropathy because may not need the (urinary) catheter. And can better manage the case with complicated history. We were aware (R1) had a urologist at (local hospital). It's written in the discharge note. Abdominal distention can occur if you retain a large amount of urine. If you have a large back up of urine, it can definitely cause Acute Kidney Damage and Hyperkalemia.

The facility does not have a policy or protocol regarding voiding trials when an indwelling urinary catheter is discontinued.

A facility policy dated February 20, 2017 and titled, "Notification for Change of Condition" documents: Procedures: 1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: c. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

A facility policy dated January 13, 2017 and titled, "Indwelling Catheter" documents: Policy

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 01/28/2019

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S9999	Continued From page 10 Statement: It is the facility's policy to ensure that no resident will have indwelling urinary catheter, unless condition shows that there is a medical reason to justify the use of the indwelling catheter. 4. A care plan for the use of the indwelling catheter will be made per policy. (B)	S9999		

LTC07202

COMPLAINT DETERMINATION FORM

FAC. NAME: BELLA TERRA MORTON GROVE
LIC. ID #: 0053223
DATE COMPLAINT RECEIVED: 11/30/18 10:59:00

COMPLAINT #: 0107668

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
199	OTHER	2

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.