

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012553	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2022
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NAME OF PROVIDER OR SUPPLIER BELLA TERRA SCHAUMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193
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S 000	Initial Comments	S 000		
S9999	<p>Complaint Investigation# 2211969/IL144555</p> <p>Final Observations</p> <p>Complaint Investigation# 2211969/IL144555</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>1 OF 2 300.1210b) 300.1210d)3)5) 300.1820c)3)</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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: 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.</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.1820 Content of Medical Records c)In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to identify a facility acquired pressure injury prior to it becoming unstageable for 1 of 3 residents (R1) reviewed for pressure in the sample of 6. The failure resulted in R1 developing an unstageable pressure injury to R1 ischium.</p> <p>The findings include:</p> <p>R1's facility assessment dated 2/19/2022 shows R1 cognition is intact and R1 requires extensive assistance of 2 staff for her bed mobility. R1's face sheet shows diagnoses including: non</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>displaced humerus fracture of the left arm, osteoarthritis, pain in left arm, weakness, and need for assistance with personal care. R1's care plan shows she is at risk for impairment of skin integrity with an intervention to check skin every shift and report any abnormalities to the nurse. R1's pressure ulcer risk assessment completed on 2/22/2022, 2/27/2022 and 3/6/2022 by V9 (Wound Care Nurse) shows that R1 is at moderate risk to develop pressure injuries.</p> <p>R1's nursing progress notes show she has a recently acquired left arm humerus fracture and as a result R1 has been bed bound since 2/19/2022.</p> <p>A facility Wound Assessment Details Report completed by V9 on 3/8/2022 at 12:16 PM, shows that R1 has a new facility acquired pressure injury to her left ischium. The wound is 3.70 centimeters (cm) long by 2.30 cm. wide by unknown depth. An area of 8.51 cm.² the wound is classified as unstageable and has 70% slough tissue.</p> <p>On 3/10/2022 at 9:35 AM, V9 removed the dressing to R1's left ischium. R1's pressure injury is approximately the size of a fist. The top layer of skin is gone and there is a white area in the center of the wound bed. V9 said that due to the slough tissue in the wound bed it is not possible to determine how deep it is underneath so the pressure injury was classified as unstageable. V9 additionally said that R1 is incontinent of urine and has been remaining in bed so she should be receiving incontinence care and turning and repositioning every 2 hours. On 3/10/2022 at 11:51 AM, V9 said that R1's wound would have initially started out as skin irritation and it should have been reported much sooner. V9 said he</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>thinks that R1's wound was just not reported early enough and "the process broke down and slipped through the cracks." "Sooner reporting is the key and at some point this wound was just a skin irritation. And treatment could have been initiated sooner, it was just too far along to justify not being reported sooner."</p> <p>There is no documented skin abnormalities in R1's nursing progress notes prior to 3/8/2022 for R1's ischium.</p> <p>On 3/10/2022 at 9:40 AM, V10 (Certified Nursing Assistant/CNA) said residents are turned and repositioned every 2 hours and incontinence care is provided. V10 said R1 is incontinent of urine and is supposed to be checked, turned and repositioned every 2 hours. V10 said she had not worked with R1 in a couple of weeks and she was the one who reported R1's pressure injury to the nurse. V10 said any changes to a residents skin even just redness or irritation should be reported immediately. V10 said that R1 has been feeling "a little down" lately.</p> <p>On 3/10/2022 at 9:50 AM, R1 said she has been in bed due to her having a broken arm. R1 said and now I have a sore on my bottom that has been hurting for a while now. R1 said she likes to be up out of bed in her wheelchair and not in bed.</p> <p>On 3/10/2022 at 10:20 AM, V11 (CNA) said all residents skin should be looked at during incontinence care which is done every 2 hours, during showers, and anytime they are doing care for a resident. V11 said any abnormal findings needs to be reported to a nurse immediately even just pink or irritated skin.</p> <p>On 3/10/2022 at 10:46 AM, V3 (Assistant Director</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>of Nursing/ADON) said that any skin abnormalities should be reported immediately.</p> <p>A nursing progress completed by V14 (Nurse Practitioner) on 3/9/2022 at 8:31 PM, says that R1 has a newly acquired ischial ulceration. The same note states, "Aides reports on going crying and she (R1) reports feeling depressed."</p> <p>V14 was attempted to be contacted by phone and a message was left by the facility and again by the surveyor on 3/10/2022 at 1:27 PM, with no return phone call.</p> <p>The facility's Wound Care Program Care Guidelines with a reviewed date of October 3, 2021 says, "3. Prevention of skin breakdown includes but not limited to: b. daily regular skin hygiene. C. inspect the skin every shift with care for signs of breakdown..."</p> <p>(B)</p> <p>2 OF 2 300.610a) 300.1210b) 300.1210d)6)</p> <p>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</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure a resident was safely transferred using 2 staff members, for 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 6. This failure resulted in R1 sustaining a left arm humerus fracture during the transfer.</p> <p>The findings include:</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>R1's face sheet updated and printed date of 2/24/2022 shows she has diagnoses including: Unspecified fracture of shaft of humerus left arm, initial encounter for closed fracture, osteoarthritis, and pain in left arm.</p> <p>R1's facility assessment dated 2/3/2022 shows her cognition is intact, and she requires extensive assistance of 2 staff members to transfer.</p> <p>R1's active care plan shows she has a self-care deficit and impaired mobility and requires 2 staff members physical assistance and the use of gait belt, using the stand pivot method for transfers.</p> <p>R1's nursing progress notes show an entry written by V6 (Registered Nurse/RN) on 2/17/2022 at 3:01 PM that states "Resident complained of pain to left arm after transfer her from bed to chair, given pain medicine as per PRN (as needed) order, MD aware with new order for left arm x-ray STAT (as soon as possible)." A entry in R1's nursing progress notes on 2/18/2022 also by V6 says, "R1's X-ray was normal and no fracture the Nurse Practitioner (V14) was notified, R1 c/o pain 6/10 given pain medication as per order, resident stay in bed because of left arm pain." R1's nursing progress notes show on 2/19/2022 at 4:30 PM, the facility received a call from the x-ray company that they are sending a tech to redo R1's x-ray. The x-ray was completed at 5:50 PM. At 8:20 PM the facility received a call that R1's x-ray shows she has a fracture to her left arm. The facility notified a nurse practitioner who then notified the family and R1 was sent to the emergency room for treatment of a left arm humerus fracture.</p> <p>R1's emergency room records from a local community hospital on 2/19/2022, show R1 was being evaluated for a left arm injury that occurred</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>during a transfer on 2/17/2022 where R1's arm was squeezed tightly. A radiology report from the local community hospital dated 2/19/2022 shows R1 has a subacute spiral fracture to her distal third left humeral shaft. R1 was discharged from the emergency room on 2/20/2022 with an arm sling and recommended to have orthopedic follow up.</p> <p>An Orthopedic note written by V15 (Orthopedic Physician) shows that R1 was seen by him on 3/1/2022. The same note shows she has a non-displaced spiral fracture of the shaft of the humerus on the left arm. The notes shows that R1 is having constant pain to the left shoulder.</p> <p>On 3/10/2022 at 9:50 AM, R1 said her arm was broke during a transfer when an agency CNA (identified as V12) transferred her alone with no gait belt and without a mechanical lift. R1 said the CNA asked her how she is usually transferred and R1 told her with a lift. R1 said the CNA told her I don't think we need that I can lift you into the chair. R1 said the CNA was alone, did not apply a gait belt, and lifted her under the arms and it happened so fast the next thing she knew she was in excruciating pain and called out that something was not right. R1 said when she was sat down in her wheelchair the pain was terrible and she could not lift her shoulder up. R1 said her roommate R4 was present in the room when the incident occurred. R1 also said since the incident she has been bed bound and that makes her upset because she likes to be up in her wheelchair.</p> <p>On 3/10/2022 at 9:57 AM, R4 said she witnessed the incident when the CNA (V12) came into the room and asked R1 how she usually transferred. R4 said V12 did not use a lift to transfer R1 and</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>she was the only CNA in the room. R4 said she heard R1 calling out ouch this is too much. R4 said no one from the facility interviewed her about witnessing the incident. R4's facility assessment dated 1/17/2022 shows her cognition is intact.</p> <p>On 3/10/2022 at 9:40 AM, V10 (CNA) said they always use 2 staff to safely transfer residents when using a sit to stand. V10 said that R1 had some weakness to her lower extremities but her upper body was strong and she could hold on to the lift. V10 said R1 has been feeling a little down lately, since the injury to her arm.</p> <p>On 3/10/2022 at 10:20 AM, V11 (CNA) said R1 was supposed to be transferred with 2 staff and using a sit to stand lift. V11 said R1 would not be safe to transfer with 1 staff person. V11 said R1 is also not safe to do a stand/gait belt transfer with 1 person. V11 said R1 should not have been transferred alone.</p> <p>On 3/10/2022 at 10:46 AM, V3 (Assistant Director of Nursing/ADON) said she interviewed V12 after the incident to R1 and V12 told her she used the sit to stand lift alone to transfer R1. V3 said their policy is 2 staff are required to be present when using a lift on a resident</p> <p>On 3/10/2022 at 11:02 AM, V6 (Registered Nurse/RN) said she was called to assess R1 on 2/17/2022 after she was transferred by V12 and complained of arm pain. V6 said both R1 and R4 are alert and oriented. V6 said an ordered was received for R1 to have an x-ray of her left arm.</p> <p>On 3/10/2022 at 11:23 AM, V8 (Restorative Nurse) said that they highly recommend 2 staff during a sit to stand transfer. V8 said even though manufacturer guidelines for a sit to stand lift says</p>	S9999		
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S9999	<p>Continued From page 9.</p> <p>you can use 1 staff we prefer 2 because, "look at the mess we are in now if something goes wrong." V8 also said the guidelines also indicate when more than 1 staff are recommended for transferring.</p> <p>On 3/10/22 at 11:35 AM, V12 said on the date in question 2/17/2022 it was the first time she had taken care of R1. V12 said she went into R1's room and asked her how she transferred and R1 told her with a sit to stand lift. V12 said she went and got the lift and while transferring R1 she began grimacing in pain, and during the transfer R1 was telling her she was having severe pain. V12 said R4 was asking R1 if she was okay during the transfer. V12 said she could transfer R1 with only 1 person.</p> <p>On 3/10/2022 at 10:40 AM, V5 (RN) said R1 and R4 are both alert and oriented.</p> <p>A nursing progress completed by V14 (Nurse Practitioner) on 3/9/2022 at 8:31 PM, says that R1 has a newly acquired ischial ulceration. The same note states, "Aides reports on going crying and she (R1) reports feeling depressed."</p> <p>R1's investigation report completed by V2 (Director of Nursing) has no witness statement from R4. The same report says that V14 (Nurse Practitioner) consulted with R1's primary care physician and indicated the residents (R1) fracture is pathological in nature and caused by the resident's fragility due to long term use of steroids and immobility and the resident has osteoporosis. In the same investigation report a witness statement completed by V12 says she was the only staff present during the transfer and says she used a sit to stand lift alone and R1 began grimacing in pain during the transfer.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>V14 was attempted to be contacted on 3/10/2022. 2 messages were left one by V2 and one by the surveyor with no return call.</p> <p>On 3/10/2022 at 12:55 PM, V15 (Orthopedic Physician) was attempted to be contacted. V15 was out of town so V4 (Orthopedic Physician Assistant) took the call and said he is V15's assistant. V4 said that a spiral fracture is not a pathological fracture. V4 said the type of fracture R1 has is consistent with trauma to R1's arm. V4 said an arm would not just fracture on its own without there being a tumor or mass present pushing on it.</p> <p>The facility's Mechanical Lift Transfers with a revised date of 7/28/2021 says to follow the manufacturer's guidance on how to operate machine. The manufacturer guidance states, "Though one person can perform patient transfers, certain patients or situations may require the help of one or more additional staff members..."</p> <p>(B)</p>	S9999		