

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint Investigation: 2399104/IL166172	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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. 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. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 1</p> <p>nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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 requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to identify supervision needs and implement measures to reduce fall risk for a confused resident at risk for falls, failed to implement plan of care interventions and falls policy to prevent resident's fall and injury. This failure affects 1 (R1) of 3 residents reviewed for accidents/incidents in the sample and resulted in R1 being emergently transferred to the hospital for hip fracture with surgical intervention.</p> <p>Findings include:</p> <p>R1 is a 94 year old male admitted to the facility on 10/22/2018 with diagnosis including but not limited to Retention of Urine, Unspecified; Polyosteoarthritis, Unspecified; Atrioventricular Block, Second Degree; Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, and Anxiety; Altered Mental Status, Unspecified; Unspecified Symptoms and Signs Involving Cognitive Function and Awareness; Unspecified Hearing Loss; Adult Failure to Thrive; and Fracture of Unspecified Part of Neck of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 2</p> <p>According to most recent MDS (Minimum Data Set) before the fall (that occurred on 10/26/2023) dated 09/01/2023, under section C, R1 has BIMS (Brief Interview of Mental Status) score of 2 indicating severe cognitive impairment; under section G, R1 needs extensive assistance, one person physical assist for transfers, and R1 not steady, only able to stabilize with staff assistance moving from seated to standing position.</p> <p>Per record review, Fall Risk Evaluation dated 09/01/2023 reads in part, "Score 4; scoring: 0-7 = low risk."</p> <p>Per record review, Fall Risk Evaluation dated 10/26/2023 reads in part, "Score 13; scoring: 8 and above = high risk."</p> <p>Per record review, R1's fall care plan reads in part, "R1 has unsteady balance, able to stabilize without staff assist, please monitor R1's balance and assist as needed. I (R1) would like staff to address my needs with a prompt response to all requests for assistance."</p> <p>On 11/13/2023 at 10:07 AM, Surveyor interviewed VB (Licensed Practical Nurse) who related the following in summary but non-verbatim: Nurses round on residents upon beginning of their shift; however, there is no rounding schedule for nurses. Certified Nursing Assistants are our eyes and ears, and they do the rounding. When we have agency CNAs, we, floor nurses, orientate them upon beginning of their shift to familiarize them with residents. There is also a list that summarizes high fall risk residents and their needs for agency staff to review. Residents' names who are on high risk for fall are also marked with gold leaf as a visual reminder.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 3</p> <p>On 11/15/2023 at 02:08 PM, Surveyor interviewed V2 (Director of Nursing/Interim Falls Coordinator) who related the following in summary but non-verbatim: The expectation on staff rounding is to have nurses and CNAs round at the beginning of their shift and at least every couple of hours throughout the rest of the shift for both, nurses and CNAs.</p> <p>On 11/13/2023 at 10:18 AM, V8 (LPN) provided memory care unit high risk fall residents' list. List reviewed, R1 not included on the high risk fall list.</p> <p>On 11/13/2023 at 10:23 AM, R1 not in the room at this time. No gold leaf observed by R1's name outside of the room.</p> <p>On 11/13/2023 at 10:35 AM, Surveyor interviewed V6 (Agency Certified Nursing Assistant) who related the following in summary but non-verbatim: Nurses give us verbal update on residents' needs, but I am not aware of any resident list pertaining to their specific needs, I've never seen it before.</p> <p>On 11/13/2023 at 02:42 PM, Surveyor interviewed V6 (Agency Certified Nursing Assistant) who related the following in summary but non-verbatim: We are vigilant when working on the third floor because it is dementia unit. I remember R1. I was the one who took care of him on the evening of 10/26/2023. R1 usually goes to bed around 7.30 pm. That evening, I came out of adjacent room, peaked into R1's room and noticed, that he was sitting on the edge of the bed, ready to be assisted to go to bed for the night. I asked R1 to give me a minute while I go to throw away the garbage. When I came back, R1 was already on the hallway floor with his</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 4</p> <p>walker beside him and his roommate standing next to him. R1 was complaining of left leg pain. I notified the nurse and R1 was sent to the hospital via 911. R1 is confused, requires 1 person assist with Activities of Daily Living and walking, although he often walks by himself, always with the walker. I don't consider R1 safe to walk by himself. R1 doesn't use a call light and is forgetful. R1 tends to walk out of the room when he needs something instead of using call light. Additionally, R1 is hard of hearing.</p> <p>On 11/13/2023 at 3:50 PM, Surveyor interviewed V9 (Licensed Practical Nurse) who related the following in summary but non-verbatim: On the evening of 10/26/2023, R1 was in the new room when he fell. R1 was not aware of new surroundings since he was moved to the new room the day before. R1's roommate thought that R1 was knocking on the door, and pushed the door as R1 was standing in the doorway. R1 might have gotten startled and fell in the hallway, right outside of the room. V6 (CNA) alerted me about the fall. I approached R1 and assessed him, including vital signs, neurological check, and checked for leg shortening as he was complaining of left leg pain. I asked R1 what happened, but he was unable to recall. R1 was just holding onto his leg, saying that it hurts. We treat all residents on memory unit as a fall risk. Fall risk resident have gold leaf by their names. R1 was ambulatory with a walker but very confused. R1 needed assistance with some Activities of Daily Living and one person assist with getting in and out of the bed.</p> <p>Per record review, hospital record dated 11/01/2023 reads in part, "R1 presents to the hospital status post hip fracture. On 10/28 (2023) R1 underwent a left hip open reduction and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 5</p> <p>internal fixation surgery" and required postoperative pain management.</p> <p>On 11/13/2023 at 04:12 PM, R1 observed asleep in the bed at this time. Bed alarm pad underneath the resident, bed alarm monitor stored away in the drawer, in the nightstand, next to the R1's bed.</p> <p>On 11/14/2023 at 11:51 AM, Surveyor interviewed V2 (Director of Nursing/Interim Falls Coordinator) who related the following in summary but non-verbatim: R1's fall investigation consisted of staff and roommate interview, we also discussed R1's fall during interdisciplinary team meeting. R1's post fall precaution interventions are: reorienting to surrounding environment and bed alarm; R1's fall precaution interventions previous to the fall were: call light within reach and proper footwear. R1 wasn't a fall risk resident before the fall. We came to this conclusion based on R1's assessments including: no previous falls, whether there was significant change, additionally, we observed R1. R1 was safe to walk unassisted. We determined that the fall that occurred on 10/26/2023 was unavoidable because R1 was pushed by the door.</p> <p>On 11/14/2023 at 3:00 PM, Surveyor interviewed V5 (Restorative Nurse/Interim Fall Coordinator) who related the following in summary but non-verbatim: On 09/01/2023, I assessed R1's Minimum Data Set, section G -Functional Status, based on CNAs documentation, restorative aid comments, and my own assessment. For sit to stand transfer, R1's functional status was graded as 3 - extensive assistance and 2 - one person assist because the CNA placed gait belt on R1 and pulled him up, R1 needed 50% assistance from staff, was unable to complete the task</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 6</p> <p>independently. Before the fall on 10/26/2023, R1 wasn't high risk fall resident; however, after the incident, R1 became a high risk fall resident. R1 needs now physical and occupational therapy due to incident/fracture. R1 is not safe to ambulate with a walker like he used to, he uses wheelchair now.</p> <p>On 11/15/2023 at 9:50 AM, Surveyor interviewed V7 (Nurse Practitioner) who related the following in summary but non-verbatim: R1 is a 94 year old male who's minimally verbal, doesn't answer questions, follows minimum commands, and is confused, only able to state his name. R1 is also hard of hearing. The main issue when communicating with R1 is not so much trouble hearing, it is his progressive dementia due to old age. I last assessed R1 before the fall (that occurred on 10/26/2023), on 08/08/2023. I didn't see him walk at that time, and even before then, R1 was mostly in his bed. R1 had overall decline in health since August of 2023. I performed full assessment, including chest x-ray and blood work, but there has not been indication of an ongoing infection, R1 has been just declining due to his age. Surveyor further clarified, if I said "(R1), I'll back in a minute, just wait for me" would R1 be able to understand that command? V7 (NP) stated, "No, I doubt R1 would understand that."</p> <p>On 11/15/2023 at 2:48 PM, Surveyor interviewed V10 (Nurse Practitioner 2) who related the following in summary but non-verbatim: (Nurse Practitioner) "I've been taking care of R1 for the last year, I see him about once a month. The biggest communication issue with R1 is that he can't hear but just agrees with you; and it has been especially challenging with staff wearing masks. R1 would not remember to use the call</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/15/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BELLA TERRA WHEELING	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 7</p> <p>light taking his BIMS score into consideration, and his dementia also plays a big role.</p> <p>"High-Risk Fall Identification Process" policy, not dated, reads in part, "The visual identifier is used to identify residents who are on the program. The identifier may be in place next to the resident's name outside of the room. By making it easy to identify high-risk resident's, staff can quickly initiate action to reduce the risk of falling and injuries."</p> <p>"Fall Occurrence" policy dated 07/17/2023 reads in part: "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. If a resident had fallen, the resident is automatically considered as high risk for falls."</p> <p>(A)</p>	S9999		