STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012553	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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S 000	Initial Comments Annual Licensure & Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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		

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S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: Based on observation, interview, and record review the facility failed to ensure fall interventions were in place for a resident who is a HIGH risk for falls and failed to ensure a resident was safely transferred. This failure resulted in R135 falling on the floor in the dining room sustaining a right femoral neck fracture and requiring surgical intervention. This applies to 1 of 2 residents (R135, R459) reviewed for safety in the sample of 31. The findings include: 1. R135's face sheet shows he is a 84 year old male with diagnosis including fracture of the right femur neck, unspecified dementia without behavioral disturbance, unsteadiness on feet, cognitive communication deficit, weakness, monoplegia of upper limb following cerebral infarction affecting right dominant side, hydronephrosis, urine retention and aphasia. R135's Final Incident Report dated 9/19/23 documents on 9/13/23, (R135) stood up from chair in the dining room and lost his balance and fell hitting the right side of his body on the floor. A staff member from a distance observed him fall. He was kept immobilized until the paramedics arrived. (R135) was transferred to the local hospital and admitted for right acute femoral neck fracture and required surgical intervention. R135's Minimum Data Set assessment dated 7/7/23 shows his cognition is impaired, requires extensive assist with bed mobility, transfers,	S9999		

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S9999	Continued From page 3 tolieting. He is not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, moving on and off the toilet, and surface to surface transfers. R135's Fall Risk Assessment dated 9/8/23 shows he is HIGH risk for falls. On 10/22/23 at 9:25 AM, R135 was observed in his room in a low bed near the nurses station. On 10/24/23 at 10:27 AM, V16 (RN) said she was R135's nurse on 9/13/23 when he fell. She was on break and was alerted by staff he was on the floor. Last time she observed R135 was about 6:30 PM, in the dining room he was self propelling in his wheelchair. R135 is alert to self, sometimes he can verbalize his needs and is unable to follow direction. He had a fall a week prior getting up without assistance. V17 (CNA) was the only staff in the dining room. He told me there were so many residents in the dining room at that time who were at high risk for falls and could not watch them all. When she entered the dining room he was laying on the floor on his right side complaining of pain. She called the ambulance and did not move him, he was admitted with femur fracture. V16 said V18 was his assigned CNA (Certified Nursing Assistant) that day and was in another residents room. There's supposed be two staff supervising the dining room for safety. On 10/24/23 at 1:08 PM, V18 (CNA) said R135 is alert to person, does not follow direction. He was R135's CNA on 9/13/23 when he fell. He's supposed to be toileted every two hours, that day he toileted him about 3:30 PM and did not take him to the bathroom after dinner. At the time of the fall he was in another residents room.	S9999		

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S9999	Continued From page 4 Residents should be toileted before and after meals, when awake, and before bed to prevent them from getting up on their own. There should be two staff in the dining room to help supervise the residents for safety reasons. On 10/25/23 at 9:59 AM, V2 (DON) said V17 is no longer an employee at the facility. She said R135 has dementia and poor safety awareness. He got up from the chair and fell and fractured his femur. She confirmed R135 was not assisted to the toilet after the dinner meal and that was an intervention they put in place after his fall on 9/8/23. It doesn't matter if there was only one CNA in the dining room that's considered supervision. We in-serviced the staff to offer tolieting to residents every two hours and frequent monitoring. On 10/25/23 at 2:21 PM, V22 (R135's Nurse Practitioner) said R135 has dementia and is alert to himself, he has poor safety awareness, and is at high risk for fall. Staff should be monitoring him closely. and he needs staff assistance for his activities of daily living. She confirmed he fell and sustained a femur fracture. R135's Post Fall Investigation Report dated 9/9/23 shows on 9/8/23 he had a fall in his room, he was attempting to stand without staff assistance. The interventions included to re-educate staff to offer toileting to the resident upon rising in the morning, before and after each meals and at bedtime. The facility's Falls Policy revised 8/20 states, "The Fall Prevention Program is designed to ensue a safe environment for all residents. Each resident will be evaluated upon admission, quarterly and as needed...to assess his/her individual fall	S9999		

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S9999	Continued From page 5 risk...implementing an individualized Plan of Care designated to meet the resident's needs. To ensure the consistency in the implementation of preventive measures to assist with the reduction of falls..." 2. R459's Admission Restorative Assessment dated 10/6/23 showed R459 required maximum assistance from staff for transferring and toileting. On 10/23/23 at 9:15 AM, V5 Certified Nursing Assistant (CNA) transferred R459, from her bed to a wheelchair, by lifting R459 under her armpits and sliding her into the wheelchair. No gait belt was used. V5 CNA wheeled R459 in her wheelchair, into the bathroom. Again, V5 CNA transferred R459, from her wheelchair onto the toilet, by lifting R459 under her armpits. No gait belt was used. Once R459 was finished going the bathroom, V5 CNA lifted R459 off the toilet by her armpits and asked her to hold onto the bar on the wall by the toilet. R459 grasped the bar and began yelling "Help me! Help me!" as V5 CNA briefly let go of R459 to wipe her. Once V5 CNA had finished wiping R459, V5 placed his hands under R459's buttocks and guided her into the wheelchair. No gait belt was used. On 10/24/23 at 11;45 AM, V2 Director of Nursing stated gait belts are to be used to transfer any resident that requires staff assistance to ensure resident safety. The facility's Gait Belt policy dated 7/28/23 showed, "The facility will use gait or transfer belts to assist residents needing limited to total assistance during transfers and walking." (A)	S9999		

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