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 _____	C 11/04/2024

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 Facility Reported Incident of 10/2/2024/IL179097	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)6) 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	S9999		

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

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.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was safely transferred for 1 of 3 residents (R1) reviewed for safety in the sample of 3. This failure resulted in R1 sustaining a laceration of 11 centimeters (cm) requiring 13 sutures.

The findings include:

R1's face sheet printed on 11/4/24 showed she was 92 years old and diagnosed with dementia, malnutrition, and peripheral venous insufficiency.

A facility assessment done on 8/29/24 showed R1 had severe cognitive impairments and was dependent on staff for transfers.

R1's Care Plan printed on 11/4/24 showed R1 had a self-care deficit and impaired mobility. Listed under interventions showed R1 was dependent on two staff for transfers. The same care plan showed R1 had a cognitive deficit such as poor safety awareness, decreased

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S9999	Continued From page 2	S9999		

comprehension, and impulsiveness. Listed under intervention was to modify environment as needed.

On 11/4/24 at 9:05 AM, R1 was in bed. R1's left leg near her shin showed a dark line/scar about 8 cm long. The dark line/scar was toward the outside of R1's leg towards her knee. There were two grape size swollen dark areas next to the dark line/scar.

On 11/4/24 at 9:05 AM, V5 (Certified Nursing Assistant- CNA) said the dark/scar area occurred while V5 transferred R1 from a shower chair. V5 said she and V6 (CNA) were transferring R1 with a mechanical lift when R1 kicked her left leg out hitting the mechanical lift causing a laceration. V5 said every once in awhile R1 will kick her legs while being transferred. V5 said R1 will sometimes follow direction and the day of the incident R1 was not following direction.

A written statement by V5 dated 10/3/24 showed on 10/2/24 while R1 was in a sling being transferred she, " ...accidentally bumped her left shin onto the base of the [mechanical lift] ..."

On 11/4/24 at 10:05 AM, V6 said on 10/2/24 after R1 received a shower he was asked by V5 to assist in transferring R1 from a shower chair to a wheelchair. According to V6, he was moving the mechanical lift and V5 was guiding R1 by being positioned by R1's trunk. V6 said R1 moved her left leg during the transfer hitting the main bar of the mechanical lift. V6 said R1 was lowered back into the shower chair and R1 was moved to her room while in the shower chair. Once R1 was in her room, she was transferred with a mechanical lift into bed. V6 said once R1 was in bed, V6 and V5 noticed R1's left leg was bleeding, and they

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got the nurse.

On 11/4/24 at 10:52 AM, V7 (Wound Care Nurse) said R1 sustained a laceration and two hematomas to her left leg during a transfer done on 10/2/24. V7 said the laceration was about 10 cm long and required 13 sutures to close. V7 added that R1 had a history of getting agitated with care.

On 11/4/24 at 11:19 AM, V9 (CNA) said when transferring a resident with a mechanical lift it takes two staff members. One staff member will move the mechanical lift and the second staff member will guide the resident to ensure there are no accidents.

On 11/4/24 at 1:01 PM, V10 said the hematoma found on 10/1/24 could have happened during a transfer. V10 added that R1 had dementia and can be restless a times.

R1's Progress Note dated 10/2/24 showed R1 had a left shin laceration with moderate amount of bleeding. The note indicated the laceration was 11 cm x 2 cm x 3 cm and R1 was sent to the emergency room.

R1's emergency room notes dated 10/2/24 showed she had 13 sutures placed to close the laceration. The same notes showed an x-ray report indicated, " ...soft tissue swelling anterior to the proximal tibia ..."

R1's health care provider progress note entered by V10 (Physician) dated 10/1/24 (one day before R1 sustained a laceration) showed R1 was seen for a hematoma to her left leg that was about the size of a grape to R1's anterior shin that had swelling and bruising. Staff found the hematoma

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S9999	Continued From page 4 during a transfer. The note indicated that the hematoma was likely caused by, " ...trivial trauma ..." On 11/4/24 at 1:15 PM, V1 (Administrator) said after the incident on 10/2/24 where R1 sustained a laceration during a transfer, padding was added to the mechanical lifts. (B)	S9999		