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	IL6013098	A. BUILDING: _____ B. WING _____	C 12/30/2024

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BELLA TERRA ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

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S 000	Initial Comments Complaint Investigations: 24710438/IL183109 24710522/IL183279	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 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	S9999		

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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

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 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.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to consult with a resident's physician when the resident had unrelieved acute gastrointestinal symptoms for 24 hours. This failure resulted in a resident calling the emergency paramedics herself for transfer to the hospital, and R6 was hospitalized for treatment of sepsis (a life-threatening complication of an infection)

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related to acute enterocolitis and aspiration pneumonia.

This applies to 1 out of 3 (R6) residents reviewed for change in condition.

The findings include:

R6's EMR (Electronic Medical Record) showed R6 had multiple diagnoses, including gastro-esophageal reflux disease, irritable bowel syndrome, emphysema, congestive heart failure, and chronic obstructive pulmonary disease. R6's comprehensive care plan (initiated 2/4/2023) showed R6 was at risk for alteration in her gastrointestinal status. R6's care plan interventions included "Give medications as ordered. Monitor/document side effects and effectiveness" and "Notify MD (medical doctor) of significant abnormalities ...abdominal pain, diarrhea/constipation."

On 12/30/2024 at 10:50 AM, V21 (Registered Nurse/RN) stated she took care of R6 on 12/23/2024 during the NOC (night) shift (7 PM-7 AM). V21 stated R6 started to have one episode of diarrhea at 7 PM and at 4 AM, R6 called reporting she was nauseous and had another episode of diarrhea. V21 stated she gave R6 a dose of her as-needed medications of Zofran (antiemetic) and Imodium (antidiarrheal) at 4 AM. V21 stated R6 did not call again regarding her GI (gastrointestinal) symptoms. V21 stated she did not contact R6's physician because R6 had as-needed standing orders for her symptoms, but informed V19 (RN) AM shift on 12/24/2024 of R6's symptoms. R6's facility EMAR (Electronic Medication Administration Record) dated 12/30/2024 showed R6 last received Zofran (antiemetic) and Imodium (antidiarrheal) as

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needed doses on 12/24/2024 at 4:00 AM. R6's progress note dated 12/24/2024 at 4:00 AM said "The patient has loose bm (bowel movement) x (times) 2 and c/o (complaints of) nausea. Loperamide 2 mg po and Zofran 4mg po given ...Day shift has been informed."

On 12/30/2024 at 11:00 AM, V20 (Agency Certified Nurse Assistant/CNA) stated she took care of R6 on 12/24/2024 during the AM shift (7 AM- 7 PM). V20 stated R6 had vomited three times and had multiple episodes of diarrhea during her shift. V20 stated R6's emesis was so extensive that she had to change her linen each time. V20 stated R6 appeared ill, and she informed V19 (RN) throughout the shift of her status.

On 12/30/2024 at 9:25 AM, V19 (Registered Nurse/RN) stated that V21 (RN) and V20 (Agency CNA) had informed him that R6 was having nausea, vomiting, and diarrhea. V19 stated he assumed R6's symptoms were related because she possibly overate chocolates. V19 stated he believes he gave R6 a dose of Zofran (antiemetic) between 10-11 AM but forgot to document it in her medication record. V19 stated he thought V21 (RN) had notified R6's physician on the prior shift. V19 stated he did not contact R6's physician because he assumed she was just having an upset stomach. V19 then stated R6 had another episode of emesis again at 6:30 PM and at 7 PM the emergency paramedics arrived to transfer her to the hospital. V19 stated he asked R6 why she called the paramedics and she said she felt she was not receiving the care she needed. V19 stated he did not remain with R6 while the paramedics were transferring her because he was giving report to the oncoming nurse but instructed V20 (CNA) to assist R6

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again because she was soiled.

R6's late entry progress note dated 12/24/2024 at 7:14 PM (written on 12/26/2024), stated "Resident vomited at 9 am and 11 am. No blood noted in vomitus ...PRN (as needed) Zofran was given. Resident vomited again at around 6:30 PM. The resident called 911 at around 7 pm and is requesting to be sent out to the hospital."

On 12/30/2024 at 10:30 AM, V2 (Assistant Director of Nursing/ADON) stated she reviewed R6's EMR and was unable to find documentation to show R6 was assessed for her unrelieved GI symptoms or that her physician was notified. V2 stated she did follow up with V19 the following day because R6's hospital transfer was unclear in her EMR. V2 stated the facility expects nurses to assess and intervene for residents when they are having a change in their condition and notify their physicians to ensure their symptoms are being treated appropriately.

On 12/27/204 at 3:00 PM, V14 (Physician) stated she expects the facility to report any resident changes and follow their care criteria processes to ensure residents are being monitored accordingly.

R6's hospital notes dated 12/24/2024 said R6 "was covered in vomit on arrival to ER (emergency room)", and was assessed for nausea, vomiting, and diarrhea. R6's hospital notes also said R6 "Claims her oral intake has been poor currently drinking sips of Coke at the most, claims she has been extremely nauseated throwing up every morning and has had multiple episodes of loose stool as well. Claims she has been feverish as well with chills and occasionally cough she also complains of shortness of

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breath." The notes continued to say R6 was being treated for sepsis related to acute gastroenteritis and aspiration pneumonia. The notes said R6 was started on intravenous fluids and antibiotics, and her diet was downgraded.

R6's hospital labs dated 12/24/2024 showed R6's WBC (white blood count) was 25.3 H (high) (normal range is between 4-11 uL). R6's hospital CT (computer tomography) scan results dated 12/24/2024 said, R6's "small bowel are nonspecific but can be seen with enteritis. Liquid stool seen throughout the colon suggestive of diarrhea. Overall constellation of findings are suggestive of a mild diffused enterocolitis, likely from infectious or inflammatory etiology." R6's hospital chest x-ray exam results dated 12/25/2024 said, R6's "chest demonstrating accumulation of right pleural effusion and scattered basilar atelectasis, with or without superimposed pneumonia."

The facility does not have documentation to show R6's physician was notified of her unresolved acute GI symptoms. R6's EMR also does not show R6 was assessed and treated according to her plan of care for her ongoing acute GI (gastrointestinal) symptoms.

The facility's General Care policy dated 7/30/2024 said, "It is the facility's policy to provide care for every resident to meet their needs ...3. During the resident's stay at the facility, the resident may be evaluated to determine that need if there is a change in condition, care can be appropriately provided including provision of emergency medical care according to the standard."

The facility's Notification for Change of Condition policy dated 8/16/2024 said, "Policy Statement

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S9999	Continued From page 6 The facility will provide care to residents and provide notification of resident change in status. 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: ...b. A significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); 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)" NO VIOLATION Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)3) 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.	S9999		

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S9999	Continued From page 7 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 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 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 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.	S9999		

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S9999	Continued From page 8 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to assess and monitor a resident who had no recorded bowel movement for eight consecutive days who was experiencing abdominal discomfort. This failure resulted in R1 having acute rectal bleeding, requiring hospitalization for a blood transfusion and emergency intravenous medication administration to reverse the effects of her blood thinner. R1 also required the insertion of a rectal tube for the management of her fecal impaction. This applies to 1 out of 3 (R1) residents reviewed for constipation. The findings include:	S9999		

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R1's EMR (Electronic Medical Record) showed R1 was admitted on 9/16/2024 with multiple diagnoses including dementia, psychosis, severe protein caloric malnutrition, anxiety, depression, diabetes type 2, hypertension, and hyperlipidemia. R1's MDS (Minimum Data Set) dated 9/17/2024 showed R1 was moderately cognitively impaired. The MDS continued to show R1 was always incontinent of bowel and required substantial to maximal staff assistance with her toileting needs.

On 12/26/2024 at 9:00 AM, V11 (R1's Family Member) stated she had a care plan meeting with V16 (Social Service Director) on 9/26/2024. V11 stated she inquired regarding R1's bowel movement because R1 expressed having rectal discomfort and had a history of constipation. V11 stated V16 informed her that the nursing staff reported R1 was having routine bowel movements. V11 stated then on 10/1/2024, she was informed R1 was transferred to the hospital for a rectal bleed.

On 12/26/2024 at 12:20 PM, V16 (Social Worker Director) stated she reviewed R1's care plan meeting documentation which did not mention specifics regarding R1's bowel concern. V16 stated she did recall asking R1's nurse on duty about her nursing care but unfortunately did not recall specifics. V16 stated only the nursing team had access to review residents' documented bowel patterns.

On 12/24/2024 at 1:15 PM, V10 (Certified Nurse Assistant/CNA) stated she routinely took care of R1 during her stay. V10 stated R1 was confused and combative at times. V10 stated she recalled informing the nurses on duty that R1 would routinely complain of abdomen discomfort. V10

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stated R1 had also been incontinent of bowel at times. V10 stated she documents residents' bowel movements in their EMRs every shift.

On 12/26/2024 at 1:10 PM, V18 (Licensed Practical Nurse/LPN) stated she took care of R1 on 9/29/2024 from 7 AM-7 PM and was concerned because R1 did not eat. V18 stated she notified the telehealth physician on call and continued to monitor R1. V18 stated she was unsure how to check for resident bowel movements in their EMRs. V18 said she depends on the CNAs to report unusual bowel issues such as constipation or diarrhea.

On 12/26/2024 at 11:00 PM, V13 (CNA) said she took care of R1 on 10/1/2024 from 7 AM-7 PM. V13 stated R1 had a large putty-like "mushy" bowel movement during the day. V13 stated that during lunch she noticed R1 was tired and leaning forward in her chair. V13 stated R1 had refused to eat, and she then assisted her to bed. V13 stated she informed the nurse on duty because she was worried that R1 also appeared very fatigued and refused to eat during the shift. V13 stated she records bowel movements in the residents' EMRs and believed nurses review the documentation.

On 12/24/2024 at 12:10 PM, V4 (Agency Registered Nurse/RN) stated she took care of R1 on 10/1/2024. V4 stated at 8:30 PM during her care, R1 was noted with a large amount of rectal bleeding and a low blood pressure. V4 stated R1 was then transferred to the hospital for further care. V4 said she recalled being informed during the shift report that R1 had a bowel movement during the prior shift but was unsure if R1 had been constipated or of her bowel patterns. V4 stated residents' EMRs alerts nurses when a

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resident has not had a bowel movement recorded for more than two-three days, which will prompt the nurses to further assess the resident.

On 12/24/2024 at 10:20 AM, V2 (Assistant Director of Nursing/ADON) stated she reviewed R1's documented bowel activity report for her stay which showed that before her bowel movement on 10/1/2024 she had only one recorded bowel movement on 9/22/2024. V2 stated the computer system alerts the nurses when no bowel movement has been documented in a three-day look back for all residents. V2 stated the facility expects CNAs to document bowel activity every shift for all residents. V2 continued to say the facility also expects nurses to check the residents' triggered bowel alerts every shift and respond, to ensure residents are being appropriately assessed and treated for constipation. V2 stated she was unsure why R1's nurses did not respond to R1's triggered alerts for no bowel movements documented for multiple consecutive days.

On 12/26/2024 at 3:00 PM, V14 (Physician) stated she had been overseeing R1's medical care during her stay at the facility but was not sure of her bowel documentation. V14 stated older residents usually have irregular bowel patterns due to slow bowel activity and poor intake, which then puts them at risk for constipation. V14 stated constipation can be treated at the facility with stool softeners, and residents can be further monitored for related complications. V14 stated she expected the facility staff to follow its process for bowel management to monitor those at risk for constipation.

R1's Care Plan (initiated 9/21/2024) showed R1

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was a risk problem for constipation related to decreased mobility and effects of medications. The care plan included the following interventions, "Monitor medications for side effects of constipation. Keep physician informed of any problems," "Monitor/document/report to MD PRN signs/symptoms of complications related to constipation: change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse), Abdominal distention, vomiting, small loose or stools, fecal smearing, Bowel sounds, diaphoresis, Abdomen: tenderness, guarding, rigidity, fecal impaction," and "Record bowel movement pattern each day. Describe amount, color, and consistency."

R1's Documentation Survey Report for bowel movements dated 12/24/2024 showed the following:
9/16/2024-9/21/2024: R1 had 6 days with no bowel movement recorded and no interventions done.
9/22/2024: R1 had one large, formed stool.
9/23/2024-9/30/2024: R1 had 8 days with no bowel movement recorded and no interventions done.
10/1/2024: R1 had one small putty and another large putty stool.

R1's Order Summary Report showed an order dated 9/30/2024 for "GlycoLax Powder (Polyethylene Glycol 3350) gram by mouth one time a day for constipation." The report also showed an as needed order for constipation dated 9/30/2024 for "Dulcolax Suppository 10 MG (Bisacodyl) insert 1 suppository rectally as needed for constipation Daily."

R1's MAR (Medication Administration Record)

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	IL6013098	A. BUILDING: _____ B. WING _____	C 12/30/2024

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BELLA TERRA ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

(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 13	S9999		

from 9/1/2024-10/1/2024 showed R1 did not receive a Dulcolax Suppository for constipation. The MAR showed R1 received 1 dose of GlycoLax Powder on 10/1/2024.

R1's Nurse's Progress Note dated 9/29/2024 at 2:44 PM, said "Noted patient have a decreased appetite today. Patient refused breakfast and lunch ...Efforts to offer drinks to hydrate and frequent small meals was also unsuccessful." The note said the telehealth physician was notified and orders were received to "Continue to monitor patient and will let the primary provider follow up tomorrow with the patient."

R1's Progress Note dated 10/1/2024 at 8:57 PM showed R1 had to be transferred to the hospital because "resident had significant blood clots and bleeding noted from vaginal or rectal area."

R1's emergency room hospital notes dated 10/1/2024 said, "Pt (patient) with large amount of rectal bleeding in ED (emergency department)." The notes said R1 was transfused with one unit of packed red blood cells and received Kcentra as an emergency intravenous medication to reverse the effects of R1's blood thinner medication to treat her blood loss. The notes continued to say R1 also had a rectal tube inserted to facilitate stool passage after receiving stool softeners for fecal impaction with stercoral colitis.

R1's CT scan (computer tomography) of the abdomen dated 10/1/2024 said, "A markedly heavy stool burden is seen throughout the colon, particularly in the rectosigmoid colon, with substantial distension of the rectal vault ...These findings are concerning for fecal impaction with stercoral proctocolitis."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013098	A. BUILDING: _____ B. WING _____	C 12/30/2024

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S9999	Continued From page 14 The facility's policy titled Bowel Management dated 7/26/2024, said "Policy Statement It is the facility's policy to record resident's bowel movement in the medical record. Procedure 1. The certified nurse aide on each shift will record the resident's bowel movements. 2. The facility will assess the resident when a resident shows sign and symptom of abdominal distress like pain, tenderness upon palpitation, rigidity, vomiting, etc. 3. If there is a change in the resident's pattern of bowel movement, the facility will notify the physician. 4. The facility will follow up to ensure that the physician's order is implemented..." (A)	S9999		