| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053223 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/18/2025 |
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| BELLA TERRA MORTON GROVE | 8425 WAUKEGAN ROAD , MORTON GROVE, Illinois, 60053 |

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| S0000 | Initial Comments<br><br>Incident Investigation of 5/22/25 /IL194435 | S0000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br><br>300.1210b)<br><br>300.3210t)<br><br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>Section 300.3210 General<br><br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interviews, and record review, the facility failed to ensure that a cognitively and visually impaired resident (R1) was treated with respect and dignity and protected from abuse during care. R1, one of three residents reviewed for abuse, suffered physical and emotional harm when two Certified Nursing Assistants (CNAs), V6 and V7, were observed on video being physically rough, threatening, and inappropriate during care provision. The facility also failed to train and monitor staff in de-escalation and behavioral management techniques appropriate for residents with cognitive impairment.<br><br>Findings include:<br><br>R1 is a 60 year old with severe cognitive impairment, visual and verbal impairments, and with diagnoses including but not limited to Alzheimer's Disease, major depressive disorder, anxiety disorder, and dementia. MDS (minimum data set) dated 5/22/25 showed R1 with severe cognitive impairment, with behaviors, and was dependent in performing activities of daily living.<br><br>R1's abuse risk assessment dated 10/10/2024, 4/18/2025, and 5/22/2025 all scored at 3 and 4 demonstrating "At Risk" with any score above a 2. | S9999 | | |

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| S9999 | Continued from page 2<br><br>R1's care plan dated 5/13/25 reads in part, "(R1) is High risk of being a recipient or perpetrator of mistreatment due to Dementia, Major Depressive Disorder. (R1) will be treated with respect, dignity and reside in the facility free of mistreatment through next review. Interventions: Conduct appropriate assessments to promote knowledge and understanding of the resident's past. Identify if there are behaviors or factors from the past that should be considered in treatment planning. Observe the resident for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help her feel safe."<br><br>A two minute video clip provided to surveyor by R1' family showed V6 (CNA) telling R1 resident "You're wet, your wet! Put your head down, I told you to put your head down! R1 is heard shrieking loudly No! No! V6 was observed in the video pushing R1's head down and restraining his chest in order to prevent the resident from getting up while V7 (CNA) is at the foot of the bed removing and pulling the resident's pants and incontinence briefs in a swift and rough manner causing the resident to give a very audible shriek. R1 was shown screaming, visibly frightened, and resisting care. No nursing supervisor appeared to have been called, and the care continued despite the resident's clear distress. Near the end of the video, V6 says to R1 again, I told you not to scream and then proceeds to slap on the right side of the residents face, whereupon the video ends.<br><br>On 6/16/25 at 9:40 AM, V1 administrator was asked to provide R1's abuse incident reported to the Illinois Department of Public Health. Surveyor asked to view the video of the incident that was sent to facility by R1's family who had permission to install a surveillance camera in the room. V1 said he no longer possessed the video but was able to explain what was observed in the video when asked by the surveyor. V1 indicated that the two CNA's (V6 and V7) were seen changing the resident in bed and that the actions of V6 and V7 did not meet the standards of the facility so they were immediately suspended and then terminated. Surveyor asked V1 to clarify his meaning of "not meeting the standards", V1 said that at one point in the video, V6 had slapped the resident on the cheek which was ultimately the deciding factor in terminating V6. Surveyor asked if V7 (CNA) in the video he viewed warranted termination as well, V1 indicated only that V7 did not meet the facility standard but declined to go into detail except V7 was | S9999 | | |

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| S9999 | Continued from page 3<br>also terminated due to an "abundance of caution".<br><br>The facility's internal incident report showed however V7 was terminated due to not reporting the incident immediately to her immediate supervisor as per the facility's abuse policy.<br><br>Facility's internal incident report provided by V1 to surveyor, reads in part, "On 5/22/25 around 2:25 PM family showed video footage of R1 having ADL (activity of daily living) done with him on 5/21/25 at around 2 PM. The video shows V6 (CNA) and V7(CNA) attempting to change (R1). (R1) was attempting to pick his head up while care was being done to him. V6 was redirecting him back to a laying position. V7 was on the other side removing R1's clothes. V5 LPN did a head to toe assessment, completed, resident did not have any abnormalities and did not complain of any pain and/or discomfort. (V6) and (V7) were both suspended. Police were notified."<br><br>(This report failed to discribe the audible screams and resistance to care of R1, the threats made towards R1 to stop screaming, and failed to report the face slap shown in the video.)<br><br>On 6/16/25 at 10:20 AM, R1 was observed in the dining area attending an activity. R1 was seated in a wheelchair and seated behind a table and appeared withdrawn and looking down at the table. Staff did not appear to try to engage the resident in any activity. Surveyor asked the resident how he was doing but the resident was unable to respond. V5 LPN was asked about R1 and said that R1 was non-verbal but had behaviors of screaming out mostly when he is in bed or during care but sometimes when he is seated in the dining room he would just scream out for no reason. V5 indicated that R1 had been relatively calm, almost "withdrawn" lately. Surveyor asked what staff did when R1 exhibited these screaming behaviors, V5 said that they would try to calm him down but did not indicate how. Surveyor asked if she was the nurse that assessed R1 after the incident involving the two CNA's on the video, V5 indicated she assessed the resident but that it was the following day of the incident so she really did not see any physical signs so that was what she wrote in her report.<br><br>On 6/16/25 10:30 V2 director of nursing said that V4 | S9999 | | |

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| S9999 | Continued from page 4<br>(assistant administrator) notified her about two CNA's assisting (R1). V2 described her observation of the video to surveyor and said, "They are changing him in bed and (R1) has behavior of shouting. At the time of changing, he (R1) was also attempting to get up and the male CNA (V6) was trying to put him back to bed 2 times and he put his left hand on his forehead and the other had pushing on the resident's shoulder towards the bed. I saw it twice (referring to the video). After that (R1) continued to be loud. They continued changing him and after changing him, I also saw V6 tapping the resident's cheek. R1 wasn't shouting after V6 tapped the the resident's cheek but prior to that he was shouting. They repositioned him on the bed and that's all I saw." Surveyor asked if the actions of V6 and V7 rose to the level of abuse, V2 said, No and that V6's tap was more of a "love tap" directed at the resident. Surveyor asked if the two CNA's she viewed in the video were too rough with the resident, V2 declined to answer and said, "It didn't meet our standard." echoing the same phrase V1 had stated to the surveyor.<br><br>A two minute video clip provided to surveyor by R1' family showed V6 (CNA) repeatedly telling the confused resident R1 "You're wet, your wet! Put your head down, I told you to put your head down! R1 is heard shrieking loudly No! No! V6 was observed in the video pushing R1's head down and restraining his chest in order to prevent the resident from getting up while V7 (CNA) is at the foot of the bed removing and pulling the resident's pants and incontinence briefs in a swift and rough manner causing the resident to give a very audible shriek. R1 was shown screaming, visibly frightened, and resisting care. No nursing supervisor appeared to have been called, and the care continued despite the resideint's clear distress. Near the end of the video, V6 says to R1 again, I told you not to scream and then proceeds to slap the the right side of the residents face whereupon the video ends.<br><br>On 6/18/25 at 12:15 PM, V7 (CNA) said that she had asked V6 her coworker to help her change R1's diapers. V7 said she did not know what they did wrong and spoke with V1 administrator about the incident. Surveyor asked if she had any type of training on how to manage R1's behaviors, V7 indicated she did online training on abuse but did not get any specifics from anyone about R1. Surveyor asked what she should do if a resident resists care, V1 said that she didn't think R1 was resisting because the resident always cry out like he did when they changed him. Surveyor asked if she saw V6 push R1's head down or slap the resident's face, V7 | S9999 | | |

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| S9999 | Continued from page 5<br>said she did not because she was busy cleaning up the resident but indicated that they both may have been too rough with R1. Surveyor asked if she recalled ever getting trained on de-escalation of resident behaviors or any dementia training, V7 said she could not recall any but remembered just signing in on an inservice sheet. V7 said "They floated me around but did not train me in dementia". Surveyor asked if the administrator or anyone showed them the video of when they were changing R1, V7 indicated she did not see the video. Surveyor asked if she was aware that her actions were being recorded in the room, V7 indicated that they were told and that there were signs saying so on the door.<br><br>On 6/18/25 at 4:30 PM, V6 (CNA) said he should not have been terminated because he is a good CNA and was just helping another coworker out. Surveyor asked if he was aware R1 was confused and could not understand direction, V6 said that he knew this but indicated sometimes the resident listened to him. Surveyor asked if he pushed R1's head down on the bed and/or slapped him in the face, V6 said that he tried to push his head down because the resident kept trying to get up when they were changing him. V6 added that he gave the resident several light taps to the cheek but that he should not have done that looking back on it. Surveyor asked if he received any training on de-escalating of R1's behaviors or dementia training in general, V6 said he could not recall. Surveyor asked if a resident is resistant to care, what he would do in the future, V6 stated, "(R1) wasn't resisting, that's how the resident is."<br><br>Abuse policy revised 4/24/25 titled "Abuse and Neglect reads in part, "It is the policy of the facility to provide professional care and services in an environment that is free from any types of abuse, corporal punishment, neglect or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. Types of abuse and examples: 1. Physical: Physical abuse includes but not limited to infliction of injury that occur other than by accidental means. Examples: Hitting, slapping, twisting, squeezing, and roughly handing. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven federal components of prevention and investigation. Training: Train employees, through orientation and on-going sessions on issues related to | S9999 | | |

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| S9999 | Continued from page 6<br>abuse prohibition, neglect, exploitation, misappropriation of property such as Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. "<br><br>Facility policy on resident rights reads in part but not limited to, "No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, The Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of the Community, nor shall a resident forfeit any of the following rights: Resident rights. The resident has a right to a dignified existence, self-determination, and those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Respect and Dignity. The resident has a right to be treated with respect and dignity, including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience."<br><br>B | S9999 | | |