STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145198	A. Building B. Wing	08/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Morton Grove	8425 Waukegan Road Morton Grove, IL 60053

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on observations, interviews, and records reviewed the facility failed to provide effective resident centered interventions for residents identified to be at high risk for falls.This affected two of three residents (R1, R3) reviewed for fall prevention. The findings include: 1.According to R1's incident report on 6/28/24 at around 12:55 PM, The nurse heard a sound by the hallway. The nurse observed R1 lying on the floor. R1 noted with minimal bleeding from the head. R1 sent to the hospital and returned with Dermabond on the right occipital area. On 8/17/24 at 11:14AM V2, CNA, said she did not know who R1 is. V2 said I have not seen him since I started working at 7:00AM today. At 11:15AM AM V3, CNA, said she did not know who R1 is. V2 and V3 are both assigned the unit where R1 resides. On 8/17/24 at 12:27PM The surveyor observed R1 in the common area across from the nurses' station get up from a chair, and began walking with rolling walker, with a seat, holding it with one hand grip, R1 began to shuffle feet, gait unsteady. R1 using the walker with 1 hand, while pushing the walker away from his body, and him walking on the outside along the walker. V3, CNA, walked past R1 and did not intervene. The surveyor observed R1 lift his walker and attempt to place it on a stationary chair. On 8/17/24 at 2:29PM V6, CNA, said on 6/28/24 I didn't see when R1 got up. V6 said I can't remember if I helped R1 use the bathroom that day. V6 said R1 sometimes needs my help using the bathroom. V6 said I didn't see R1 when he fell . On 8/17/24 at 3:35PM V9,the nurse said I was charting and I heard a noise, when I looked R1 was on the floor. V9 said R1's walker was by his side and he was bleeding. V9 said R1 had been walking with his walker before the fall. V9 said I don't remember what position R1 was in on the floor. V9 said the walker was standing there but it had moved out of his reach. V9 said R1 was using a walker with a seat that day. V9 said I don't think it was a witness fall. V9 said R1 was not being aggressive or angry. V9 said (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 fell near the nurses' station, near the bathroom. V9 said R1 did have a history of falling before that day. V9 said for safety we make sure R1 is using the walker, sometimes he forgets his walker and will bring the walker for him. On 8/17/24 at 1:36PM V1, Psychotropic/Fall Nurse, said on 6/28/24 R1 had an unwitnessed fall with injury. V1 said R1's was ambulatory with a walker. V1 said the nurse on duty heard a noise and observed R1 on the floor. V1 said R1's walker was V1 at his side. V1 said R1 is very impulsive, with cognitive impairments, BIMS of 5/15, means severe cognitive impairment, and he has weakness. V1 said R1 forgets his limits and how to use the walker, he has impaired balance and unsteady gait without the use of a walker. V1 said after the fall, R1 received glue to his head. V1 said R1 uses a walker all the time. V1 said therapy said he needs the walker. V1 said R1 uses a rolling walker with a seat. V1 said R1's has very aggressive behaviors, like he can be agitated and hit people, R1 swings the walker at people. V1 said R1 is followed by psyche and is receiving medications for the behaviors that can put R1 at risk for falls. V1 said if R1 is seen not using the walker properly, then staff should give it to him. V1 said R1's ambulation status with a walker is supervision. V1 said it has been determined that the walker is still safe to use for R1. Fall Risk Evaluation notes R1 is at High Risk for falls on 5/24/24. R1's care plan documents R1 is at high risk for falls related to cognitive impairment, decline in functional status, and Impulsivity or poor safety awareness. R1 is described as being able to walk, gait is described as unsteady. R1's Cognitive assessment dated [DATE] score is 5, severe cognitive impairment. R1's Administration Record documents he received Seroquel 100mg in the evening and afternoon (8:00PM and at 1:00PM) and 75mg in the morning (9:00AM) everyday in June 2024. R1 also received Sertraline 50mg at 9:00AM everyday in June. Progress note dated 8/14/24 states able to speak with R1's daughter regarding R1's walking assistive device (AD). Educated on how to decrease fall risk. Daughter agreeable to bring rollator home and to have the patient use a regular walker. R1's care plan initiated 4/25/24 notes he is at high risk for falls related to cognitive impairment, decline in functional status, impulsivity or poor safety awareness, use of antidepressants and antipsychotic medication and recent fall. Interventions include reminders because R1 has periods of forgetfulness, staff to frequently reorient, offer toileting before bedtime to minimize the risk of R1 getting up unassisted. R1 at risk for altered thought process, initiated on 4/25/2024, due to diagnosis include but are not limited to Cerebral Infarction, Vascular Dementia, and Need for Assistance with Personal Care. Interventions include offer cues, direction and redirection as needed. Remove potentially harmful items out of reach. R1 demonstrates impaired cognitive function due to a diagnosis of other sequelae of cerebral infarction. BIMS: 5/15. Intervention include Cue, reorient and supervise him as needed. R1 requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting). No specific intervention is documented for R1's ambulation assistance. R1's record documents a fall on 5/24/24; 6/28/24; and 8/2/24. R1 sustained a skin tear to his head on 5/24/24. R1 sustained a skin tear on his right elbow on 8/2/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation following the fall on 6/28/24 notes: R1 was walking with a walker, was awake, agitated, and confused, and has poor safety awareness. Upon return from evaluation at hospital R1 has medical glue to right occipital area. Fall was unwitnessed resulting in an open area. R1 is very impulsive, forgets his limits and how to use the walker at times. He has impaired balance, weakness, and unsteady gait without the walker. Hospital records note R1 was seen in the hospital on 6/28/24 for Head Injury and Laceration. Progress note dated 8/14/24 states able to speak with R1's daughter regarding R1's walking assistive device (AD). Educated on how to decrease fall risk. Daughter agreeable to bring rollator home and to have the patient use a regular walker. 2. R3 diagnosis include but are not limited Sepsis, Cognitive Communication Deficit, Difficulty in Walking, Abnormalities of Gait and Mobility, Dementia, Unspecified Intellectual Disability, Epilepsy, and other Disorders of the Brain. On 8/17/24 at 11:03AM surveyor touring the unit and observed R3 in bed with a low bed, and a floor mat in place. On 8/17/24 at 11:14AM R3 observed by the surveyor, who is standing in the hallway outside of R3's room, walking in his room near the foot of his bed, urinary drainage bag attached to R3 and seen hanging along R3. R3 barefoot, incontinent brief undone and hanging from him. No alarm sounding when R3 got up and out of bed. V2, CNA, said R3 is not my patient, I am not sure what his care needs are. On 8/17/24 at 12:42PM the surveyor asked V4, RN, what the wire under R3's bed is for. V4 said it leads to the alarm, V4 held up a black alarm box resting on the nightstand next to R3's bed. Wire observed connected to pad alarm under R3. V4 said the alarm should sound if he up. The surveyor asked if there should be lights flashing on the alarm if it is on, V4 said I don't know if they flash. On follow up at 4:04PM V4 said It was my mistake I did not check R3's alarm when I came on at 7:00AM today. V4 said I was not aware R3 has an alarm until we were looking at it. On 8/17/24 at 3:35PM V9, Nurse, said R3 sometimes he tries to walk unassisted, and he is unsteady, he is being monitored. V9 said R3 has an alarm in use. V9 said I hear it(alarm) lots of time. V9 said I can hear the alarm in the hall and all the way to nurses station. V9 again said it goes off lots of times. V9 said we have a few alarms on the unit. V9 said when we come on nurses an CNAs do rounds to be sure the alarms are on and working. On 8/17/24 at 1:36PM V1, said R3 is at high risk for falls due to developmental delay. V1 said R3's safety interventions include the bed in the lowest position, call light in reach, and keep things in reach. V1 said we try to closely monitor R1 by watching him in the dining room and he uses a wheelchair for mobility but can walk. V1 said we don't use restraints; we do use floor mats and alarms for interventions. V1 said alarms will be activated when the person tries to stand up. V1 said some of the alarm boxes don't flash when they are on. V1 said alarms are loud so they can be heard from the hallway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/24 at 1:47PM V8, Director of Nursing, said the staff follow a get up list and they follow resident preferences to know when to assist the residents out of bed. V8 said everyone will get up, unless they are bed bound. V8 said we have a blue binder on each unit with the get up list, fall risk people, and who needs an alarm. V8 said the nurses and CNAs are responsible to check the alarms are on. V8 said the CNAs should check the alarms on their shifts, whenever they need to on the shift. Progress Note dated 8/2/24 states R3 is confused and constantly gets up from bed and not easily redirectable. Progress Note 8/1/24 notes alert but needs redirection at all times. High risk for fall due to poor safety awareness. Gait is unstable at this time, but always attempted to stand and walk by himself. Needs close monitoring at all times and extensive assist in ADLs and transfers. 8/1/24 Progress notes R3 attempted to get out of bed and walk multiple times and refused to be redirected. R3's care plan initiated on 7/16/24 notes R3 is at risk for falls related to Cognitive Impairment, Decline in Functional Status, Impaired Balance, Impulsive and Poor Safety Awareness, and Muscle weakness from recent hospitalization . Interventions include Bed alarm to alert staff when R3 attempts to get out of bed unassisted. The facility Fall Occurrence Policy dated 7/26/24 states 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.