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	03/12/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on interview and record review the facility failed to notify resident's family member of discontinuation of medication after holding the hypertensive medication. The facility also failed to notify the physician of increase in resident's blood pressure. This deficiency affects one (R1) of three residents reviewed for Notification for change in condition. Findings include: On 3/11/25 at 2:39PM, V6 Family members said that R2's amlodipine (antihypertensive medication) was completely stopped when she only gave permission to old it for 4 days as discussed with V23 Nurse Practitioner. On 3/11/25 at 2:50PM, Reviewed R2's medical records with V3 Director of Nursing (DON). R2 is admitted on [DATE] with diagnosis listed in part but not limited to Hypertension, Cardiomyopathies, Sick sinus syndrome, Heart failure, Chronic kidney disease, Cardiac pacemaker, Dementia, severe with mood disturbance, Type 2 Diabetes mellitus, Abnormalities of gait and mobility. Physician order sheet indicated Amlodipine Besylate give 1 tablet by mouth one time daily for Essential hypertension. Progress notes dated 2/2/24 documented by V24 RN indicated that he notified V23 Nurse Practitioner (NP) of change in condition because of BP (Blood Pressure) taken at 9:20am was 124/64 and at 10:00am at 118/mmHg. V24 documented V23 ordered to stop amlodipine. V6 Family member notified, did not consent to stop. Request to put amlodipine on hold for 4 days, V6 to call cardiologist and update facility. V24 RN notified V23 NP. February Medication administration record (MAR) for 2/1 and 2/2/25 indicated no blood pressure parameters for administration of Amlodipine. Amlodipine was not given after 2/2/25. Daily blood pressure obtained from 2/1/25 to 2/27/25 indicated ranges of blood pressure from 118/65 to 168/mmHg. Informed V3 DON of R2's Increased episodes of blood pressure after Amlodipine were discontinued on 2/2/25 on the following dates without notification of physician or Nurse Practitioner: 2/3/25- 143/99; 2/4/25- 161/79; 2/5/25- 146/84; 2/6/25- 149/67; 2/8/25- 168/81; 2/9/25- 156/82; 2/14/25- 147/80. V3 said that the nurse should notify the primary care physician or NP of increased BP. V3 DON said that V24 RN was following order of V23 NP of discontinuing amlodipine on 2/2/25. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 3:31PM, V23 Nurse Practitioner said that she was covering NP for R2's primary care physician. She was called by the nurse on 2/2/25, and she spoke with V6 Family member. She said that she ordered on hold the amlodipine for 4 days as she discussed with V6 Family member. She denied ordering to discontinue the amlodipine. She said that she will not discontinue a cardiac medication of resident who has hypertensive with cardiac medical issues whom she has not seen R2. She was not notified of R2's discontinued amlodipine and episode of increased in BP after discontinued. Facility's policy on Notification of change of condition revised 8/16/24 indicated: Policy statement: The facility will provide care to resident 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. c. A need to alter treatment significantly (need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to provide necessary treatment and care in a timely manner to resident with language barrier who has been refusing to get up for Restorative walking program, scheduled shower, and complaint of severe pain (during therapy evaluation) after a fall incident to identify fracture of sacrum. This deficiency affects one (R1) of three residents reviewed for Quality of care. Findings include: On 3/11/25 at 12:17PM, Rounds made to R1 with V4 Fall coordinator. Observed R1 sleeping in bed. R1 opened her eyes when called but will go back to sleep. She is lethargic but arousable. V16 Receptionist at bedside said that she was directed to do 1:1 supervision/monitoring to R1 at 10:00AM. V16 said that she does not document monitoring dome to R1, she just informed the floor nurse every hour. V4 said that R1 was placed on 1:1 every hour monitoring. She pointed the monitoring form for today started at 3/11/25 at 12AM placed by the window. V4 handed the hourly monitoring form to surveyor. Reviewed monitoring form and informed V4 that no monitoring form was done from 12AM. Surveyor asked V18 Receptionist, why she did not document her 1:1 hourly monitoring started at 10:00AM. V18 said that she did not know about the monitoring form, no one told her how to document. V16 said that since she started at 10:00AM, R1 has been sleeping. On 3/11/25 at 11:54AM, Reviewed R1 medical records with V3 DON (Director of Nursing). R1 is readmitted /27/24 with diagnosis listed in part but not limited to Fracture of Sacrum, subsequent encounter for fracture with routine healing, Fall subsequent encounter, Acute pain due to trauma, Anemia in chronic kidney disease, Type 2 Diabetes mellitus with diabetic neuropathy arthropathy, Heart failure, chronic kidney disease stage 4, Cardiac pacemaker Supravalvular aortic stenosis. Physician order sheet for January and February 2025 indicated that R1 has hydrocodone-acetaminophen oral tablet 5-325mg give 1 tablet by mouth every 6 hours as needed for pain (PRN) up to 7 doses. Lidocaine external patch 4% apply to affected area (lower back) topically in AM, on for 12 hours and off at bedtime (HS). Admission pain assessment indicated no pain complaint. MDS/resident assessment dated [DATE] indicated Section J-no pain and Section N- no administration of prn pain medication. Fall assessment indicated that she is at high risk for fall. Comprehensive care plan indicated that she is at risk for acute and chronic pain due to current medical conditions. She has some difficulty in expressing self and understanding others due to language communication barrier. She has impaired thought processes related to impaired decision making. She has impaired self-care deficit and impaired mobility. She is at high risk for falls related to decline in functional status, impulsivity to poor safety awareness, muscle weakness from recent hospitalization . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 has history of unwitnessed falls:1) 1/16/25 at 8:00PM indicated that nurse heard a scream from room. Nurse and CNA (Certified Nurse Assistant) went to the room and observed R1 on the floor, lying on the floor next to her bed. R1 claimed that she was trying to get her phone because someone was calling her, and her phone was charging in the wall by the fridge. 2) 2/8/25 at 8:10PM, Nurse was alerted to R1's room due to a loud noise and call for help. R1 was observed sitting on the floor near the door. R1 was asked what happened, but due to language barrier was not understood. Daughter was called to assist with translation. Daughter translated that R1 would like to sit. Daughter came to see R1. R1 complained of left hip pain. She cannot ambulate with walker due to pain. Nurse offered pain medication. Nurse Practitioner recommended to transfer R1 to hospital for evaluation, but Daughter refused and preferred X-ray to be done at the facility. Care planned was updated. Therapy to evaluate and treat R1 to increased strength and mobility and prevent further falls. Xray was done on 2/9/25 indicated no fracture. R1's post fall comprehensive pain assessment dated [DATE] but signed 2/15/25 indicated no pain. R1's post fall comprehensive pain assessment dated [DATE] but signed 2/16/25 indicated no pain. R1's post fall incident 72 follow up (2/9/25 to 2/11/25) for fall incident 2/8/25 indicated no pain but signed and locked date 2/17/25. Informed V3 DON that all pain assessment was completed after the resident was discharged to the hospital on 2/13/25. R1's Pain assessment every shift documented in MAR (Medication administration Record) indicated no complaint of pain in all shifts from 3/9/25 to 3/13/25. MAR indicated that R1 was only given twice of as needed pain medication (Hydrocodone-Acetaminophen orally) from 3/8/25 to 3/13/25. R1's Restorative program log from 2/9/25 to 2/13/25 indicated refusal of walking program after the fall incident on 2/8/25. R1's shower and bathing documentation indicated that she refused shower scheduled on 2/10/25 after the fall on 2/8/25. Informed V3 DON that there is no documentation in the progress notes of reason of R1 refusal of treatment and care. V3 said that R1 has the right to refuse treatment and care. R1's Physical therapy (PT) evaluation and plan of treatment dated 2/12/25 indicated: Evaluation only. Reason for referral: Patient is [AGE] years old female resident of this facility status fall referred to PT for eval only and treatment x1 to establish functional baseline and appropriate restorative program for functional maintenance. Other system/condition assessment: Patient has pain that interferes/limits functional activity? YES (Patient complaint of severe pain both lower extremities. Nurse on duty informed and aware. Pain assessment method-Patient verbalized pain level. Is skilled therapy needed to address pain? Nursing to address. R1's Facility reported incident dated 2/13/25 reported to IDPH on 2/14/25 indicated that R1 is observed with facial grimacing and guarding of her lower back. R1 was sent out to the hospital due to intractable pain on lower back. R1 was admitted at orthro unit with diagnosis of closed fracture of the sacrum. CT of thoracic spine was done with impression of acute left sacral ala fracture 182 series 2 with adjacent presacral soft tissue. R1 returned to facility on 3/7/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's comprehensive care plan indicated that she has some difficulty in expressing and understanding others. Her primary language is (URDU- an Indo-[NAME] language spoken in Pakistan and parts of [NAME]). She primarily speaks a different language than many of the caregivers, becoming frustrated when unable to understand a message or convey her message. Interventions: Involve a translator to ais in communication. In some situation a family member may serve as a translator. As Necessary, have the translator assist in developing a personalized communication board or book. Utilize appropriate augmentative devices, i.e., communication board/flash cards, pads, etc. Help acquire and learn to us appropriate devices. On 3/11/25 at 1:10PM, V5 Restorative Nurse said that she is not aware that R1 has been refusing to get up for the restorative walking program after she fell on [DATE] not until 2/13/25. V5 said that if resident refused restorative treatment program, she expects the restorative aide who provides the treatment to report to her so that she could document reason for refusal, assess the resident and inform family member of refusal of program. On 3/11/25 at 1:25PM, V17 Restorative Aide (RA) said that R1 refused to get up for the restorative daily walking program. She was not able to participate due to pain and wanted to stay in bed to sleep. She did not inform V5 Restorative Nurse and R1's family of R1 refusal of walking program. V17 said that R1 has language barrier. She used hand gestures to communicate to R1. She did not use translator or communication board. She said that she only notified V5 of R1's refusal on 2/13/25. On 3/11/25 at 1:30PM, Rounds made to R1's room with V17 RA. Observed R1 sleeping in bed. Remains lethargic but arousable. Observed V18 CNA at bedside. V18 said that she was asked by her supervisor to be a sitter to R1 while the receptionist is on break. V18 said that she does not know why she has to monitor R1 because R1 has been sleeping since she arrived. She said that there is no monitoring documentation endorsed to her. On 3/11/25 at 1:46PM, V19 Restorative Aide said that R1 refused to get up for the restorative daily walking program after she fell on [DATE]. She was not able to participate due to pain and wanted to stay in bed to sleep. She did not inform V5 Restorative Nurse and R1's family of R1 refusal of walking program. V17 said that R1 has language barrier. She used hand gestures to communicate to R1. She did not use translator or communication board. On 3/12/25 at 11:18AM, V21 Family member denied that they refused R1 to be sent out to the hospital for evaluation due to lower back pain after the fall incident on 2/8/25. V21 said that she is the responsible party for R1. She said her other sister probably the one they spoke to. She said that R1 was in so much pain after the fall and the medication was not effective. R1 was crying in pain. She said that they requested R1 to be sent to the hospital on 3/13/25 due to severe pain. She said that she was not notified of R1 refusal of shower and restorative program due to pain. On 3/12/25 at 12:08PM, V20 CNA said that she is regular CNA for R1, she said that after she fell on [DATE] she complained of pain on her lower back. She cannot get up and stand up. She reported her pain to the floor nurse. She cannot remember the name of the nurse. On 3/12/24 at 12:13PM, V9 RN said that she took care of R1 on 2/11/25 (she was off from 2/8 to 2/10/25. She said that she was not endorsed to her during nursing report that R1 fell on [DATE]. She learned it from R1's family member. R1 complained of severe pain of 10/10 to her lower back and gave prn pain medication. She did not call her doctor because everyone knows that she complaint of pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 2:30PM, Informed V1 Administrator and V2 DON of above concerns identified in Pain management. The inconsistency of pain assessment. Documentation of pain assessment after the R1 was discharged . Communication among IDT (Interdisciplinary team) of resident refusal of treatment due to pain. Implementation of care plan and policy on communication barrier. Because of these they failed to provide necessary treatment and care in a timely manner to resident with language barrier who has been refusing to get up for Restorative walking program, scheduled shower, and complaint of severe pain (during therapy evaluation) after a fall incident to identify fracture of sacrum. Facility unable to provide policy on Reporting and documentation of reason of resident refusal to treatment and care. Facility's policy on Pain revised 1/30/25 indicated: Policy statement: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. For pain complaints and for situations/incidents that might result to pain (ex: fall incident, altercation, cuts, bruises, wound care, etc.) the nursing staff may document in any part of the resident's medical record that may include nurses' notes, incident report, medication administration record, etc.) Procedures: 1. Upon admission and readmission, the nurse will assess resident for pain. For those identified with pain upon admission/readmission assessment, an order for pain medication will be obtained from the physician. A paper-based assessment or UDA is available for use. The pain medication ordered will be administered to the resident as soon as possible. After administration of prn pain medication. If the resident is still unrelieved of pain despite pharmacologic and nursing measures, the resident's physician will be called to refer the lack of relief. Facility's policy on Quick reference guide for language line solutions/How to access an interpreter. *When receiving a call 1. Use your phone's conference feature to place the limited English proficient (LEP) speaker on conference/hold 2. Dial [PHONE NUMBER] 3. Provide your client ID# 4. Select the language you need b. Press 2 for all other language and state the name of the language you need. Press 0 for agent assistance if you do not know the language. 5. Provide your facility name: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Brief the interpreter. Summarize what you wish to accomplish and provide any special instructions. 8. Say End of call to the interpreter when your call is completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure appropriate infection control practices after providing shower to a resident in the shower room. This deficiency affects one of three common shower rooms in resident's unit reviewed for resident clean environment. Findings include: On 3/11/25 at 2:39PM, V6 Family member said that the common shower room shared by residents is dirty and not cleaned. Resident's soiled clothes, towels and wash cloths are left in the shower room. On 3/11/25 at 10:58am Observed shower room by [NAME] Unit with soiled resident clothing on the floor, towels, and wash clothes. Showed observation to V7 Housekeeping supervisor. V7 said that the CNA (Certified Nurse Assistant) should place all soiled clothes, towels, and wash clothes in plastic bag not on the floor after shower. Informed observation to V11 LPN (Licensed Practical Nurse). V11 said that V12 CNA should place all soiled clothes, towels, and wash clothes in plastic bag not on the floor after shower for infection control. On 3/11/25 at 11:26AM, V1 administrator said that V6 Family member already presented the concerns last month and they addressed it already. Presented copy of grievance/concern form completed by V22 Social Service Director dated 2/21/25. Informed V1 of above observation made and concern of shower room in [NAME] unit is dirty with soiled resident clothing, towels, and wash clothes on the floor. On 3/11/25 at 11:54AM, Informed V3 DON (Director of Nursing) of above concern. Requested for policy. On 3/11/25 at 12:09PM, V12 CNA said that he gave shower to R6. He forgot to place the soiled resident's clothing, used towels and wash cloths in the plastic bag after giving shower to R6 instead of leaving it on the floor. He said that he should not leave the soiled clothing, towels, and wash cloths on the floor in the shower room. It should be place in plastic bag then put it in soiled utility room. On 3/11/25 at 2:30PM, V3 DON that aftercare after providing shower to the resident is to gather all soiled clothing, towels and wash cloths used and placed it in plastic bag not on the shower floor. V3 said that they don't have policy. Facility unable to provide policy on Aftercare after providing resident shower and maintaining resident clean environment.