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	06/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that a cognitively and visually impaired resident (R1) of 3 residents reviewed in the sample of 3, was treated with respect and dignity during the provision of care. This failure resulted in physical harm when two Certified Nursing Assistants (CNAs) were observed on video being physically rough with R1, including forcefully pushing the resident's head and torso down on the bed while resident was actively resisting and crying out, threatening the resident to stop screaming, and slapping the resident's face during care. Findings include:R1 is a [AGE] 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. 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.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.On 6/16/25 at 9:40 AM, V1 administrator was asked to provide R1's 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 he 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, V1 indicated only that it did not meet the facility standard but declined to go into detail except that (V7)was also terminated due to an abundance of caution. The facility's internal incident report showed however V7 was terminated due to not reporting the incident immediately to her immediate supervisor.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. (This report failed to report the audible screams and resisting care of R1, the threats made towards R1 to stop screaming, and failed to report the face slap shown in the video.)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. Surveyor asked 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. Surveyor asked what staff did when R1 exhibited these behaviors, V5 said that they would try to calm him down but did not indicate how. On 6/16/25 10:30 V2 director of nursing said that V4 (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)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to train/monitor staff on behavior de-escalation, failed to protect a cognitively and visually impaired resident from abuse for 1 (R1) of 3 residents reviewed for abuse in the sample of 3.This failure resulted in physical and emotional harm inflicted on a vulnerable resident when two Certified Nursing Assistants (CNAs) were observed on video footage being physically rough with R1, including forceably pinning the resident's head and torso down on the bed while resident was actively resisting and crying out, threatening the resident to stop screaming, and slapping the resident's face during care. Findings include: R1 is a [AGE] 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. R1's abuse risk assessment dated [DATE], 4/18/2025, and 5/22/2025 all scored at 3 and 4 demonstrating At Risk with any score above a 2. 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. 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 also terminated due to an abundance of caution. 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. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	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. (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.) 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. On 6/16/25 10:30 V2 director of nursing said that V4 (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. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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. 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. 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 abuse prohibition, neglect, exploitation, misappropriation of property such as Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the care plan interventions related to behavioral management for one (R1) of 3 residents reviewed for care plans in the sample of 3 cognitively impaired residents. Two Certified Nursing Assistants (CNAs) did not follow the care-planned strategies for managing care-resistant behavior, resulting in a care interaction that placed the resident at risk for emotional distress and escalation. Findings include: R1 is a [AGE] 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. 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. Another care plan dated 3/6/24 reads in part, Verbally physically aggressive behavior.(R1) demonstrates behavioral distress Being challenged by a dementia related illness, Ineffective coping mechanisms, Poor self-esteem, feelings of inadequacy, Poor verbal skills and inability to express self in more appropriate language. He frequently screams/yells when receiving shower or being toileted despite staff's re-direction and encouragement. Goal: (R1) will refrain from verbally and/or physically aggressive behavior following staff interventions through next review. Interventions: Compliment resident on successfully completing meals and group activities without inappropriate behavior. Explain Rules of Conduct and each person's obligation to treat others with dignity and respect at all times. Intervene by speaking calmly and professionally in a soft tone of voice. Staff should avoid raising own voice, since this tends to make him more upset. This may cause the situation to escalate. 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. (This report failed to document 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.) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. On 6/16/25 10:30 V2 director of nursing said that V4 (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. 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 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 the the right side of the residents face whereupon the video ends. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that services provided to one (R1) of 3 residents in the sample of 3 with cognitively impairment met professional standards of quality; specifically two Certified Nursing Aides (CNAs) did not follow the established plan of care for managing care-resistant behavior, engaged in physically rough handling of the resident during care, and failed to utilize person-centered behavior interventions resulting in care interaction that did not meet accepted clinical practice standards. Findings include: R1 is a [AGE] 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. 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. Another care plan dated 3/6/24 reads in part, Verbally physically aggressive behavior.(R1) demonstrates behavioral distress Being challenged by a dementia related illness, Ineffective coping mechanisms, Poor self-esteem, feelings of inadequacy, Poor verbal skills and inability to express self in more appropriate language. He frequently screams/yells when receiving shower or being toileted despite staff's re-direction and encouragement. Goal: (R1) will refrain from verbally and/or physically aggressive behavior following staff interventions through next review. Interventions: Compliment resident on successfully completing meals and group activities without inappropriate behavior. Explain Rules of Conduct and each person's obligation to treat others with dignity and respect at all times. Intervene by speaking calmly and professionally in a soft tone of voice. Staff should avoid raising own voice, since this tends to make him more upset. This may cause the situation to escalate. 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. (This report failed to document 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.) (continued on next page)

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	06/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. On 6/16/25 10:30 V2 director of nursing said that V4 (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. 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 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 the the right side of the residents face whereupon the video ends. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure that two Certified Nursing Assistants (CNA's) demonstrated the necessary competency in dementia care and behavior management techniques for one (R1) of 3 residents reviewed in the sample of 3, who exhibited care-resistant behaviors, did not apply de-escalation strategies as directed in the resident's care plan, placing the resident at risk for increased agitation and emotional distress. Findings include: R1 is a [AGE] 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. 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 him feel safe. 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. 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. (This report failed to report the audible screams and resisting care of R1, the threats made towards R1 to stop screaming, and failed to report the face slap shown in the video.) (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Surveyor asked 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. Surveyor asked what staff did when R1 exhibited these behaviors, V5 said that they would try to calm him down but did not indicate how. 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 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. 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.