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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Bella Terra Morton Grove		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 - 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** Based on interview and record review, the facility failed to ensure monitoring and supervision of a bedbound, high fall-risk resident on strict COVID isolation, and failed to consistently implement required fall prevention interventions. This failure affected one (R1) of four residents reviewed for safety and supervision and resulted in R1 not being visually observed or assessed for a period of over two hours and culminated in R1 being found unresponsive on the floor and pronounced deceased in the facility. Findings include:R1 is a [AGE] year-old male, admitted in the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus with Hyperglycemia; COVID 19; Unspecified Injury of Head, Subsequent Encounter; Encounter for Surgical Aftercare following Surgery on the Nervous System; Syncope and Collapse; and Paroxysmal Atrial Fibrillation. MDS (Minimum Data Set) dated [DATE] documented a BIMS (Brief Interview for Mental Status) score of 11 which means moderate impairment in cognition. MDS also recorded R1 uses wheelchair and had not attempted to walk due to medical conditions or safety concerns. R1's POS (Physician Order Sheet) recorded:[DATE] - Isolation-droplet precautions, Reason for isolation: COVID 19 positive every shift[DATE] - May need to use 2 1/2 partial bedrails to enhance functional independence and promote skin integrity. Fall risk evaluation dated [DATE] documented R1 scored 9, meaning high risk for fall. According to progress notes dated [DATE] documented at 9:12 AM, R1 was observed on the floor, unresponsive and not breathing. Vital signs taken, blood pressure 106/66; pulse rate 171; respiration was 0; oxygen saturation was 54% room air. Cardiopulmonary resuscitation (CPR) started; nonrebreather mask applied with 15 liters of oxygen; intravenous access was attempted to be started; additional help arrived; Automated External Defibrillator (AED) applied; shock was not advised twice. Paramedics arrived and took over. At 9:58 AM, R1 was pronounced dead. On [DATE] at 3:29 PM, V5 (Agency Certified Nursing Assistant, CNA) was asked regarding R1. V5 stated, On [DATE], I did not see him at all. My shift starts at 7AM to 3PM. When I arrived that morning, the night shift CNA was not there so I did not get any reports for residents. I asked the nurse on duty for reports for the group I had, she said she is not familiar, so I need to ask the night shift nurse. We did not go room to room. We did not go to his room. The only report I got for him was to check and change and he has COVID. Around 8-8:15 AM, I went to his room to pass his breakfast tray. When I went there, he was not in his bed. I thought he went out for an appointment. I didn't check the bathroom; I didn't go around the room. I didn't see him in the room. I did not check the other side of the bed. His bed, at the time, was not in a low position. There were no side rails up on both sides of the bed. I left and continued to pass the breakfast trays. I went back to his room an hour later to get his tray, but it was untouched. I asked the nurse, said he may be in dialysis, I said, Oh, ok, I will leave his tray and warm it up later. An hour later, they found him and came to let me know what was going on. It was my first time taking care of him.On [DATE] at 3:57 PM, V6 (Social Services Director) was interviewed regarding R1 and incident on [DATE]. V6 replied, On that day, (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 - Actual harm Residents Affected - Few	I was doing rounds, between 9 to 10 AM. He was in isolation for COVID. I knocked, no response, so I entered the room. I didn't see him in the bed. So I went around the bed, I noticed his feet and legs sticking out from under the bed. Most of his body was under the bed. I found him in that space under the bed, between the window and the bed. I tried to call his name he did not respond. I called the nurses. They went to the room and took over from there. His bed was not in the lowest position. I don't know if he was high risk for fall. He was unresponsive at the time. On [DATE] at 10:35 AM, V7 (Licensed Practical Nurse, LPN/Rehab Nurse) was asked regarding R1's incident on [DATE]. V7 verbalized, It was V4 (Registered Nurse, RN) who was the nurse on duty for R1. R1 was COVID positive and was placed in a single room for isolation. I just finished passing morning medications and was sitting at the nurses' station, V6 came to me, and said he (R1) was on the floor in his room. It was around 9:15 AM. Myself and V4 responded to his room immediately. We noticed that he was laying between the heater and bed, more on under the bed, unresponsive. We didn't see his chest rising, no eyes opening, no verbalization, no communication. He was under the bed; the bed was not in lowest position. We called code and started CPR (cardiopulmonary resuscitation); he was full code. Oxygen was also administered. Paramedics came and took over. V7 was asked regarding R1's mobility and monitoring. V7 continued, He needs assistance with mobility, he was bedbound, unable to walk. He was not a dialysis patient. He was on isolation for COVID 19. We monitor residents on isolation every hour. Nurses do odd numbered times and CNAs do even numbered times. It was an agency CNA who worked with him (R1) at that time. When agency CNA comes in, I usually ask them if they have worked here before and if they verbalized, they were and know their assignments, I'll just tell them to call me if they have any questions. If they verbalized, they haven't been here, I print the census and I go from room to room and endorse accordingly. To my knowledge, they said he (R1) was last seen at 6:30 AM. V9 (LPN) mentioned during interview on [DATE] at 10:55 AM that R1 was alert, oriented to self and place, needs assistance, can't walk, bedbound. V9 also emphasized that every hour monitoring should be performed to residents on isolation; also making sure fall interventions such as bed in lowest position, side rails up as ordered; should be in place for fall risk residents. R1 is on strict isolation precautions and high risk for fall. On [DATE] at 11:34 AM, V4 was asked regarding R1 and incident on [DATE]. V4 stated, He was alert but spoke different language. He was in isolation, in a private room. He was COVID positive, on complete isolation; door is to be closed. On [DATE], I got reports in the morning that he was sleeping in bed comfortably during night shift and had no issues. I went to pass medications. I passed the medications until 9 AM. I have not physically seen him since I started working for the morning shift. My shift starts at 7 AM. But the CNA (V5) passed trays around 7:30 AM to 8 AM, I assumed she (V5) passed his tray and seen him. Around 9 AM, somebody called code blue, and everybody was rushing to his room. I went there, me and V7. He was on the floor, under the bed, unresponsive, pulseless. We called for help. CPR started. Paramedics were called, came in and took over. He passed away in the facility. For isolation residents, we monitor them every one to two hours for vital signs, making sure they are okay. He had COVID and coughing, unable to walk. I believed the CNA (V5) mentioned that he (R1) was not in his room. I was busy with medication passing that time and not thinking, and since I had another resident going out for an appointment that day and a dialysis patient, I told her (V5) that he (R1) might be in dialysis. I got mixed up with another resident, my mistake, and not thinking. I didn't check him (R1) in his room to verify. Since he was in isolation, he should be monitored every one to two hours. He was not a fall risk resident. For fall risk resident, we always make sure the bed at the lowest position. On [DATE] at 12:01 PM, V11 (RN/Fall Coordinator) was asked regarding R1's monitoring and fall interventions. V11 verbalized, Based on my evaluation he (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was a high fall risk. We implemented call light within reach, personal items within reach, no clutter on the floor, reminders to ask for assistance, bed in low position always, changing positions slowly especially when transferring, both quarter length side rails up all the time. He sometimes plays with the bed remote but we have to make sure his bed is in low position. He was alert, oriented, speaks little English. He was able to verbalize needs and wants. R1 was on isolation for COVID 19 positive. In preventing falls on residents on isolation, staff need to do rounds every one hour and check residents' status; make sure all the interventions in the care plan are followed, especially bed position, bedside table and personal items within reach. During change of shift, the outgoing staff should give reports to incoming staff related to residents. R1's care plan documented:1.High risk for falls related to decline in functional status, impaired balance during transitions, impulsivity or poor safety awareness, muscle weakness, syncope and history of falls prior to admission ([DATE]):Intervention: Prefer to keep the bed in the low position for safety. 2. Has an active COVID 19 diagnosis, requires a single room, strict isolation, and contact droplet precautions ([DATE]):Intervention: Monitor resident for change in condition especially with respiratory distress. 3. May need to use 2 1/2 partial bedrails to enhance functional independence and promote skin integrity ([DATE]):Interventions: Would like to utilize (2) partial siderails to define bed parameters; Would like to use (2) partial siderails (2) to prevent potential for injury related to medical condition. On [DATE] at 12:28 PM, V3 (Assistant Director of Nursing/Infection Control Preventionist) stated during interview, For residents on isolation or COVID positive, the doors should be closed; monitoring should be done every hour for COVID residents. We assigned the nurses to do the odd numbers for the hour rounding and CNAs will do the even number hours. We check the residents' condition, if they are having respiratory symptoms, we have to do vital signs, assess resident and notify physician and family regarding change in condition. We also have to check fall mats, call light, bed in lowest position, half side rails to make sure everything is in place for high fall risk residents. On [DATE], he (R1) was in isolation due to being COVID positive. He should be on strict isolation and monitored on an hourly basis. We have an internal policy called routine resident checks which was in service to staff. Staff shifts start at 7 AM to 3:30 PM; 3 PM to 11:30 PM and 11:00 PM to 7:30 AM. For isolation residents, we educated staff to do hourly rounds. They do the documentation for the hourly rounds in the progress notes. A review of R1's progress notes dated [DATE] showed no documentation that he was observed and monitored every hour that started [DATE] when he was placed on isolation precautions. On [DATE] at 10:25 AM, V14 (RN) was asked regarding R1's condition on [DATE] night shift. V14 stated, On [DATE], I was the night nurse for him. He had COVID, he was placed on isolation. He was bedbound, unable to walk. On [DATE], report was given to morning nurse V4. He (R1) had no concern during night shift, with stable vital signs, and took his medications without any problems. I saw him at 6:30 AM and he was in bed, lowest position, sleeping comfortably. No signs of distress were noted. He was in isolation, and we do hourly monitoring on him. We go to his room and check, assess him for any unusual signs. CNAs also do rounds alternating with nurses but I do it every hour. We don't document the hourly observation; we were told not to do documentation. On [DATE] at 2:15 PM, V13 (Medical Director) was interviewed regarding expectation on staff related to monitoring and fall prevention. V13 stated, Facility has a clear protocol for monitoring patients/residents. CNAs and nurses see patients/residents during rounds. Nurses distribute medications and able to see residents. CNAs has protocol for fall residents that they follow. Nurses and CNAs see residents at the beginning of their shift and see residents every two hours to check, especially incontinent residents, regardless if these residents are on isolation or not. Nurses has to check if patients/residents are not in room. When I do (continued on next page)

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