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	04/17/2025

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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. 46344 Based on interview and record review, the facility failed to follow their visitation policy allowing residents to receive 24-hour visitation privileges. This failure has the potential to affect all 154 residents currently residing in the facility. Findings include: Per daily census dated 4/14/2025 shows there were 154 residents residing in the facility. On 4/14/2025 at 12:45PM, V25 (Family Member/POA) said the facility is restricting my visiting hours and making me leave by 8:00PM. V19 (Nursing Supervisor) comes around at 7:50PM and waits for me to leave. She will tap her phone showing me the time and will not leave R113's room until I leave the facility. I feel as if I am being punished because I make sure the staff is caring for R113 and they want me gone. On 4/15/2025 at 1:00PM the resident council meeting was held which included: R60, R1, R20, R89, R121, R54, R24, R28, R59, R84, and R90. The residents agreed that at 8:00PM, the facility makes any visitors leave. At 1:30PM, V19 said our visitation policy states that all visitors need to leave once the receptionist is gone for the day, which is 8:00PM. At 7:50PM, the receptionist will check the sign-in sheet to let me know what visitors are still in the building. At this time, I will go around and remind the visitors that visiting hours are over and it is time to leave. At 3:15PM, V24 (Receptionist) said I was told that our visitation policy states that visitation ends at 8:00PM every day. At 7:50PM, I check who is still in the building and let the manager on duty or V19 aware of who is still here. They will then make rounds and let the remaining visitors know that visitation is ending and politely ask them to leave. Visitation Policy with last revision date of 8/19/2024 states in part but not limited to the following: It is the policy of this facility to allow authorized visitation of the resident in the facility at any given time. Visiting hours if from 8:00AM daily but 24-hour access is available to immediate family, other relatives, and other authorized persons visiting with the consent of the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 Note: The nursing home is disputing this citation.	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** 46344 Based on observation, interview, and record review, the facility failed to ensure a resident was free from threats and mental abuse. This failure applied to one of one (R113) residents reviewed for abuse and resulted in psychosocial and emotional harm to R113 as evidenced by emotional distress and physical anxiety. Findings include: R113 is a [AGE] year-old female who originally admitted to the facility on [DATE] and continues to reside in the facility. R113 has multiple diagnoses including but not limited to the following: Moyamoya disease, dysphagia, altered mental status, conversion disorder with seizures, transient cerebral ischemic attack, and cerebral aneurysm. On 4/14/2025 at 12:45PM, V25 (family member/POA) said we have a camera in R113's room to ensure R113 is being cared for properly. On 3/13/2025 at around 5AM, V20 (Certified Nursing Assistant) was changing R113's incontinence brief and had her completely naked. She had had a bowel movement. V20 rolled R113 on her left side which caused her to be in pain. R113 started kicking and swinging her arms which is her way of communicating that she is in pain. V20 then told R113 No, no, you better stop, or I am going to leave you here like this. Which to me means V20 is threatening R113 that she is going to leave her in a vulnerable condition, naked and lying in poop. It is to be noted that at this time R113 starting hysterically crying and observed heightened distress. R121 and V25 attempted to console and calm down R113. V25 said See, anytime we talk about this she gets extremely upset. On 4/15/2025 at 10:45AM, R121 said I was present when V20 was changing R113 on 3/13/2025. I was laying in bed when I heard R113 pounding on the side of the bed. She does this to communicate that she is in pain. I asked V20 to stop because she is in pain. I told her that R113's left shoulder hurts her and you have R113 laying on her left shoulder. V20 told me Let me do my job. R113 then started kicking her legs and kicked V20. V20 then told R113 If you do not stop, I will leave you here like this. R113 was naked and uncovered when V20 said this. I felt as if this was a threatening statement. Per MDS (Minimum Data Set) dated 4/5/2025 shows R121 has a BIMS (Briefs Interview of Mental Status) of 15, meaning resident is cognitively intact and alert and oriented. At 1:50PM, V25 showed this surveyor the video of R113 and V20. It is to be noted that the video was dated 3/13/2025. The video showed V20 changing R113's incontinence brief. R113 was observed to be in bed, in her room, naked and laying on her left side. R113 started banging on the bed and kicking her legs. V20 then said No, no, don't do that or I will leave you here like this in poo. Observed R121 laying in the bed across the room from R113. V25 said I showed this video to V1 (Administrator) where he watched and heard the audio. I do not feel like anything was done about this. She is still working in the facility where she can treat another resident like this. (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 Note: The nursing home is disputing this citation.	On 4/16/2025 at 9:45AM, V1 said V25 told me that she had a video that she wanted me to see. When I watched the video, I observed V24 changing the resident and R113 swinging her arms and kicking during care. R113 has a behavior of doing this. Asked V1 if she feels as if V1 is vulnerable to abuse because of these behaviors in which he said 'I guess so, yeah'. Asked V1 if the staff receive any sort of training on how to take care of residents with behaviors such as R113 in which he could not answer. Facility Abuse Policy with last revision date of 7/1/2024 states in part but not limited to the following: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. Mental abuse includes but is not limited to humiliation, harassment, threat of bodily harm, punishment, isolation (involuntary, imposed seclusion) or deprivation to provoke fear of shame.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to properly investigate an allegation of abuse. This failure applied to one of one (R113) resident reviewed for abuse. Findings include: R113 is a [AGE] year-old female who originally admitted to the facility on [DATE] and continues to reside in the facility. R113 has multiple diagnoses including but not limited to the following: Moyamoya disease, dysphagia, altered mental status, conversion disorder with seizures, transient cerebral ischemic attack, and cerebral aneurysm. On 4/14/2025 at 12:45PM, V25 (family member/POA) said we have a camera in R113's room to ensure R113 is being cared for properly. On 3/13/2025 at around 5AM, V20 (Certified Nursing Assistant) was changing R113's incontinence brief and had her completely naked. She had had a bowel movement. V20 rolled R113 on her left side which caused her to be in pain. R113 started kicking and swinging her arms which is her way of communicating that she is in pain. V20 then told R113 No, no, you better stop, or I am going to leave you here like this. Which to me means V20 is threatening R113 that she is going to leave her in a vulnerable condition, naked and lying in poop. On 4/15/2025 at 10:45AM, R121 said I was present when V20 was changing R113 on 3/13/2025. I was laying in bed when I heard R113 pounding on the side of her bed. She does this to communicate that she is in pain. I asked V20 to stop because she is in pain. I told her that R113's left shoulder hurts her and you have R113 laying on her left shoulder. V20 told me Let me do my job. R113 then started kicking her legs and kicked V20. V20 then told R113 If you do not stop, I will leave you here like this. R113 was naked and uncovered when V20 said this. I felt as if this was a threatening statement. R121 said at no time did anyone interview me about this incident. I thought this was strange and not right because I was an eyewitness. I feel as if the facility is not doing anything about this incident. Per MDS (Minimum Data Set) dated 4/5/2025 shows R121 has a BIMS (Briefs Interview of Mental Status) of 15, meaning resident is cognitively intact and alert and oriented. At 1:50PM, V25 showed this surveyor the video of R113 and V20. It is to be noted that the video was dated 3/13/2025. The video showed V20 changing R113's incontinence brief. R113 was observed to be in bed, in her room, naked and laying on her left side. R113 started banging on the bed and kicking her legs. V20 then said No, no, don't do that or I will leave you here like this in poo. Observed R121 laying in the bed across the room from R113. V25 said I showed this video to V1 (Administrator) where he watched and heard the audio. I expressed my concern with what she verbally said to [NAME] and the aggressiveness she used to change her. I do not feel like anything was done about this. She is still working in the facility where she can treat another resident like this. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/16/2025 at 9:45AM, V1 said V25 told me that she had a video that she wanted me to see and she was unhappy with the care. When I watched the video, I observed V24 changing the resident and R113 swinging her arms and kicking during care. R113 has a behavior of doing this. Asked V1 if she feels as if V1 is vulnerable to abuse because of these behaviors in which he said 'I guess so, yeah'. V1 said V20 was doing regular care and I did not see any sort of abuse in the video. This surveyor asked V1 if he listened to the audio of the video and he said 'I may have, yes, but I can't remember.' Then said V20 told R113 that if she does not stop this behavior, she will have to step out and get the nurse. I remember V25 being concerned about what V20 said to R113. Facility Reported Incident dated 3/25/2024 states in part but not limited to the following: Date and time alleged incident occurred: During 11-7 shift on 3/19/2025. On 3/25/2025 at 1:50PM, V25 (family member/POA) told V1 (Administrator) that she felt as if V24 (Certified Nursing Assistant) last week did not treat R113 appropriately during care. V25 showed V1 a video of V24 changing R113 and R113 was laying on her left side. V25 felt this was abuse as she felt she should on be changed on her right side. It is to be noted that at no point does the facility reported incident discuss the verbal statement V24 made towards R113. It also does not show any interview from R121, R113's roommate that was present at the time of alleged incident. The report also shows a date of an alleged event of 3/18/2025 when the video observed is clearly dated 3/13/2025. It is also to be noted that on 4/14/2025, this surveyor requested complete investigation for alleged incident of abuse with V20 and R113. Per witness statements received, no interview was noted with R121. On 4/16/2025 after interview with V1, this surveyor was provided with new, updated witness statements that were not originally presented on 4/14/2025. Facility Abuse Policy with last revision date of 7/1/2024 states in part but not limited to the following: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. Investigations: Interview all involved person including victim, perpetrator, witnesses, and other who might have knowledge of the allegation. Thorough documentation of the investigation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to ensure that staff provide scheduled shower and grooming for residents who are dependent on staff for Activities of Daily Living (ADL). This failure affected four (R41, R70, R108 and R129) of eight residents reviewed for ADL care. Findings include: R129 is [AGE] years old and have resided at the facility since 2024, face sheet listed the following past medical history: metabolic encephalopathy, chronic obstructive pulmonary disease, pain in left shoulder, chronic kidney disease stage 4, bilateral primary osteoarthritis of left hip, obstructive sleep apnea, type 2 diabetes, etc. 04/14/25 12:40PM, R129 was observed in her room sleeping and unable to answer any questions, noted with contracture to both hands, heel boots noted on a chair at the side of the room, no splint noted on both hands. Resident's hair was observed to be thick and matted, dry skin noted all over resident's body. 04/15/25 11:50AM, R129 was observed again in bed, awake and alert, stated that she is doing okay. R129's hair was still matted, dry and flaky skin all over her face and body, both legs look dark with flaky skin, her face was very dirty, and she had long fingernails on both hands with brownish substances underneath. Surveyor asked resident if she get her showers or bed bath and she said that sometimes staff will wash her up in bed, she does not receive any showers and cannot remember the last time her hair was washed. R129 asked surveyor if she can help her with her grooming because it is poor. Minimum Data Set (MDS) assessment dated [DATE], section C (cognition) scored R129 with a BIMs score of 5, section GG (functional status) of the same assessment coded R129 as being dependent to needing substantial/maximal assistance from staff for all activities of daily living. Resident have the following order dated 12/24/2024, Skin assessment weekly on shower day every day shift every Mon, Thu. Care plan initiated 8/27/2024 states the following: resident requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) related to Musculoskeletal impairment. Goal: Resident will be assisted with ADLs as needed. Interventions include assist resident with shower/bathing per schedule, Encourage participation in ADL's, etc. 04/15/25 at 12:03PM V13 (LPN) said that R129 hair is all crumpled up and needed to be washed and combed, she will get the C.N.A to trim her nails. V13 was asked if she ever saw resident get a shower and she said that she have seen them bring her to the shower room but have not actually witnessed her being showered. V13 added that the certified nurse assistants (C.N. As) are supposed to document the showers in the computer under task. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/16/25 at 12:33PM, V2 (DON) said that residents are scheduled for showers two times a week and as needed, part of Activities of Daily Living (ADL) care is washing their hair and trimming the fingernails when needed. If a resident prefers a bed bath, then it will be documented as their preference and refusal of ADL care should also be documented. Facility does not have any documentation that resident refuses showers or preferred bed baths. Surveyor requested documentation of resident's showers and skin assessments and received 2 skin assessments dated 12/92/2024 and 3.24/2025. ADL shower and monitoring document presented by facility showed that for the question, did resident take a shower, bath or bed bath, the response was no, for the months of January, February, March, and April 2025. Except on 1/23/2025, 2/13/2025 and 2/20/2025 when the response was yes. Shower and hygiene policy revised 8/19/2024 states in policy statement: it is the policy of this facility to ensure that resident shower/hygienic care is provided by the nursing staff to promote cleanliness, provide comfort to the resident, and observe the condition of resident's skin. Under procedures. The policy states in part, 1. Administer resident shower once weekly and/or as necessary. Any resident who needs hygienic care will be provided care to promote hygiene (facial, body, perineal care, etc.) 3. Shower refusal by the resident shall be relayed by the assigned C.N.A to the charge nurse. 11. Documentation (Shower log/CNA assignment sheet) a. Date and shift the shower /bath was performed. D. If the resident refused the shower and /or if shower was not administered and interventions taken e.g. bed bath/re-scheduling the shower schedule consistent to facility protocol. 46344 On 4/14/2025 at 11:10AM, R70 was observed to be laying in bed. This surveyor noted resident to be unkempt with long beard. R70 said I have not gotten a shower or been groomed in over a month. Said sometimes the staff will wipe my armpits with wipes but I have not gotten a shower or bed bath in over a month. R70 showed this surveyor his nails which were observed to be very long. Said I want my beard shaved and my nails cut. Facility Report titled ADLs (Activities of Daily Living) Shower/Bathing shows the last time R70 received a shower was on 2/21/2025. There is no documentation of shower/bathing after 3/7/2025. 34516 On 04/14/25 at 10:23 AM R41 was observed in bed and appeared uncomfortable. R41's face was wet with perspiration and in need of washing. The resident's thinning hair appeared greasy and matted on the side of his head where he slept. R1 stated, I can do some things myself but I need help to shower or to wash my face and comb my hair but it's not easy getting that help here. Care plan dated 7/8/24 reads in part, (R41) requires assistance with ADL's (bed mobility, transfers, dressing, personal hygiene, eating and toileting). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/15/25 09:22 AM R108 was in a bed that was on the ground, with his feet outside of his sheets. His feet did not have any socks and revealed toe nails that were long and in need of trimming. Resident had matted hair and there was a noticeable body and urine odors present in the room. Per V6 (LPN) R108 only receives bed baths. R108's care plan reads in part, Functionally Incontinent of both Bowel and Bladder related to Physical Limitations and Cognition. R108 will remain free from skin breakdown due to incontinence and brief use, I would like the Activity staff notify nursing if I had an incontinent episode during activities. I prefer to use disposable briefs. I would like the staff to check me for incontinence episode every 2 hours and as needed. I would also need assistance to wash, rinse and dry my perineum. I would also need assistance to change clothing after incontinence episodes. There were no care plans to address bathing and grooming found in R108's medical record when requested.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to ensure that staff provide ordered service to a resident with decreased range of motion by failing to apply ordered splints to resident's hands. This failure affected one (R129) of one resident reviewed for rehabilitation services. Findings include: R129 is [AGE] years old and have resided at the facility since 2024, face sheet listed the following past medical history: metabolic encephalopathy, chronic obstructive pulmonary disease, pain in left shoulder, chronic kidney disease stage 4, bilateral primary osteoarthritis of left hip, obstructive sleep apnea, type 2 diabetes, etc. 04/14/25 12:40PM, R129 was observed in her room sleeping and unable to answer any questions, noted with contracture to both hands, heel boots noted on a chair at the side of the room, no splint noted on both hands. Resident's hair was observed to be thick and matted, dry skin noted all over resident's body. 04/15/25 11:50AM, R129 was observed again in bed, awake and alert, stated that she is doing okay. R129's hair was still matted, dry and flaky skin all over her face and body, both legs look dark with flaky skin, her face was very dirty, and she had long fingernails on both hands with brownish substances underneath. Resident had contracture on both hands and her nails on the left hand were digging into her palm and she was unable to open her hands. Physician order dated 3/11/2025 reads as follows: Nursing /Rehab: Assistance with Splint or brace: Resident will be assisted in left- and right-hand palm protector for at least 2-4 hours or as tolerated, may take off for showers, ADLs, check the skin for any redness and/or any skin concerns and report to NOD/MD. Care plan initiated 8/27/2024 states the following: resident requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) Musculoskeletal impairment. Intervention include assist with application of appliances if needed (hearing aid, eyeglasses, dentures). Minimum Data Set (MDS) assessment dated [DATE], section C (cognition) scored R129 with a BIMs score of 5, section GG (functional status) of the same assessment coded R129 as being dependent to needing substantial/maximal assistance from staff for all activities of daily living. 04/15/25 at 12:03PM V13 (LPN) who is the assigned nurse for R129 said that she is not aware of any splints for the contracture on resident's hands, the only thing resident have is the neck pillow that she is aware of. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/15/25 at 2:20PM V18 (Restorative Aide) said that he provides restorative care to resident every time he works Monday through Friday, V18 was asked if he provided any restorative care to resident yesterday (4/14/2025) and he said no, the last time was on Sunday. Resident verbalized that no one provided any restorative care to her on Sunday. Surveyor asked V18 about resident's contracture on both hands and if he noticed the fingernails that is digging into her palm, and he said yes, her nails need to be trimmed and the resident was supposed to have a splint on both hands to prevent further contracture. V18 looked around and found one splint on resident's side table and stated that she was supposed to have 2, he does not know what happened to the other one. V18 also said that all the staff are aware that resident is supposed to use the splints and they are supposed to assist resident with putting them on. Restorative nursing policy revised 8/19/2024 stated in policy statement: It is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Under procedure, the policy states in part: #3 nursing and restorative services may include the following: C contracture prevention and management:(i)PROM/AROM exercises.(i) splint/orthotic management.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516 Based on interviews and record review, the facility failed to provide a sufficient number of nursing staff to ensure call lights were answered in a timely manner to assist with activities of daily living care, toileting, and overall care. This failure has the potential to affect all 154 residents currently residing at the facility. Findings include: On 04/14/2025 at 10:00 AM, V2, the Director of Nursing, presented the survey team with a facility matrix report, showing 154 current residents. R153 is an alert and oriented [AGE] year-old resident of the facility, with a BIMS score of 15 with diagnosis including heart failure; paroxysmal atrial fibrillation; need for assistance with personal care; and other abnormalities of gait and mobility. On 04/14/2025 at 12:50 PM, R153 told the surveyor that on the weekends, her unit only had one nurse and one CNA, and that was not enough. R153 said that about two weekends ago, it took five hours for her to get a dry diaper. When asked by the Surveyor how she determined the wait time, R153 responded she timed it, starting at 4:00 PM until 9:00 PM, and pointed at the clock on her wall, directly in front of her bed. R153 said when the CNA finally arrived, she was told the previous CNA on shift had left without providing a report. Lastly, R153 said that if a nurse had simply entered her room that day and told her they were having trouble with staff, she would not have been speaking to the Surveyor. R16 is an alert and oriented [AGE] year-old resident of the facility, with a BIMS score of 15 with diagnosis including spinal stenosis, lumbar region with neurogenic claudication; morbid (severe) obesity due to excess calories; type 2 diabetes mellitus with diabetic polyneuropathy; and post-laminectomy syndrome. On 04/14/2025 at 1:15 PM, R16 told the surveyor that the facility was understaffed on weekends and had addressed the issue with the facility director when he first arrived. R16 said he has had to wait for staff to respond to his call light, anywhere from forty to sixty minutes, about five different times, so far, during his stay at the facility, mostly during the 3:00 PM to 11:00 PM shift. R16 said that if the facility staff would communicate and tell him there was a delay, he would be fine, but they haven't. Lastly, R16 said he has been greatly concerned that if something serious were to happen to him, staff may take forty to sixty minutes to respond to his call light. (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	04/17/2025

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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/16/2025 at 1:00 PM, the surveyor spoke with V23, a family member of R100 and R48. V23 told the Surveyor that R48 told her that at around 7:00 PM on a Saturday, about one month ago, she found R100's diaper soiled. V23 said that R48 called her on her mobile phone so V23 could call the facility's front desk in order to notify the staff that R100 had a wet diaper because R48 had had no success locating any staff to help. V23 said she, then, called the front desk and the receptionist transferred the call to the nurse's station, but no one would answer. V23 said she called the front desk about three or four times, and each time, the receptionist would apologize for no one answering the phone at the nurse's station, even saying, they may not be doing their job. V23 also said that R48 told her that on weekends, she has looked out of her room in search of staff, and the hallway has appeared empty. R48 is an alert and oriented [AGE] year-old resident of the facility, with a BIMS score of 6. Her pertinent medical diagnosis include, but are not limited to, type 2 diabetes mellitus with diabetic neuropathy, unspecified; age-related osteoporosis without current pathological fracture; anemia; and hypertension. On 04/16/2025 at 1:22 PM, R48 told the surveyor that she called V23 on the phone about a month ago, at about 8:00 PM, to let her know R100 had a wet diaper and no staff was available to help. R48 said she pushed the call light button two times but no staff answered the call. V48 said about one and a half hours later, at around 9:30 PM, she confirmed that a male CNA was changing R100's brief. R48 also shared that on a different occasion, she walked to the bathroom, unassisted, because no staff answered her call light for help to use the bathroom. On 04/15/2025 at 2:00 PM V8, an RN, told the surveyor that she has been receiving complaints from residents regarding overnight lights staying on. V8 added that, in some cases, she has even seen, herself, a delay in CNA response time to resident call lights. V8 said she has shared the complaints with V10, the CNA supervisor. On 04/16/2025 at 1:40 PM, V9, an RN, told the surveyor that agency staff on weekends bring a different vibe; so, she feels like she has to watch them a little more. V9 also said she has had to reinforce to staff the importance of answering call lights in a timely manner, in the past. On 04/16/2025 at 12:30 PM, V2 told the surveyor that sometimes she has received complaints, from both residents and their families, regarding prolonged call light response. V2 said the majority of the complaints come from phone messages left over the weekend by family members of residents. On 04/16/25 at 10:14 AM, V1 Administrator, told the surveyor he has not received any notification from staff regarding residents complaining to them of prolonged call light response time on the weekends. During resident council held on 4/15/25 at 1:06 PM, R60, R1, R20, R89, 121 , R54, R24, R121, R54, R28, R59, R90, and the resident council president R84 and family member were present during the resident council meeting task. Surveyor asked the group about call light responses and the unanimous concern was the long wait times for staff to attend to their call lights. Surveyor asked what was considered long, resident group indicated that there were wait times between 30 to over 3 hours with weekends being the worst wait times. (continued on next page)

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	145198	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's call light policy, revised 07/26/2024, states, in part, It is the policy of this facility to ensure that there is prompt response to the resident's call for assistance, and the facility shall answer call lights in a timely manner.