STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145511	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Lombard	2100 South Finley Road Lombard, IL 60148

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on interviews and record review, the facility failed to ensure that a resident was free from misappropriation of prescribed narcotic medication. This applied to 1 of 4 residents (R1) reviewed for narcotic/controlled medications. The findings include: The EMR (Electronic Medical Record) showed that R1, a [AGE] year-old with diagnoses that included dementia, alcohol dependence, bipolar disorder, pain in left shoulder, low back pain, fractured left femur, obstructive and reflux uropathy, limitation of activities due to disability, and cardiac arrythmias. R1 was admitted to the facility on [DATE]. The MDS (Minimum Data Set) dated 5/3/2024 showed that R1's cognition was severely impaired with BIMS (Brief Interview Mental Status) score of 6/15. The care plan dated 4/27/2024 showed an intervention to provide prescribed pain medications to R1 for pain management. The care plan also identified R1 with impaired cognitive function, impaired thought processes related to dementia, bipolar disorder, alcohol dependence, major depressive disorder. The POS (Physician Order Sheet) for the month of 7/2024 showed a physician order dated 5/24/2024 for R1 to have Norco 5/325 mg. (controlled/narcotic medication) 1 tablet every 4 hours as needed for pain management. The order was changed on 7/8/2024 for Norco 5/325 mg. to every 6 hours as needed from the original order of every 4 hours. The pharmacy manifest list showed that the facility had received 30 tablets of Norco 5/325 mg on 6/8/2024 and another 30 tablets on 6/28/2024 for R1. The EMAR (Electronic Medication Administration Record) for the month of 6/2024 and 7/1-7/2024 were reviewed. The EMAR showed that for the month of 6/2024, R1 had received 11 tablets of Norco 5/325. The month of 7/1 through 7/7 of 2024 showed that R1 had received 11 tablets of Norco 5/325 mg. This showed that there should still be available Norco for R1 with 60 tablets supplied and 22 tablets used. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's incident report dated 7/13/2024 showed that an incident of misappropriation of R1's Norco 5/325 mg. was identified on 7/7/2024 at 11:45 P.M. The report also showed that V4(LPN/Licensed Practical Nurse/routinely scheduled staff night on the dementia unit floor, (where R1 resides) had reported that R1's Hydrocodone 5/325 mg. (Norco) was identified missing during the change of shift narcotic count between her and V3 (RN/Registered Nurse from agency staffing). The facility incident report also showed that V3 was narrowed down as the alleged perpetuator. The incident report also documents that the facility notified the local police, public health and replaced the missing medication for R1. Review of the staffing schedule on 7/6/2024 and 7/7/2024 showed the following nurses on duty on the third floor. They were same nurses for the 2 days that took care of R1. -7/6/2024 and 7/7/2024 for day shift (7:00 A.M.- 3:00 P.M.) was V5 (RN/Registered Nurse/in house staff/routinely assigned to R1) -7/6/2024 and 7/7/2024 for evening shift (3:00 P.M. -11:00 P.M.) was V3 (RN/ from agency staffing) -7/6/2024 and 7/7/2024 for night shift (11:00 P.M. -7:00 A.M.) was V4 (LPN/Licensed Practical Nurse/in house staff/ routinely assigned to R1) On 7/16/2024 at 1:58 P.M., V5 said that she was routinely scheduled to the dementia unit and assigned to R1 during the day shift. V5 said she was scheduled day shift on 7/6 and 7/7 of 2024. V5 said that during the change of shift narcotic count with V3, R1's Norco 5/325 mg. of 7-9 tablets were accounted for based from the narcotic count sheet. V5 said that on 7/7/2024, at changed of shift at 3:00 P.M. again with V3, narcotic count was done. V5 said that R1's Norco was accounted and there were approximately 7-8 tablets. V5 said that since she was regularly assigned to R1, she knows how R1 was being managed with pain which was Norco daily given around early morning. V5 said it was really weird when narcotic count held at the change of shift between her and V4 on 7/7/2024 night/morning shift. V5 said that both of them (V4 and V5) have noticed that (R1) narcotic count sheet showed that (V3) signed off indicating that V3 took 3 tablets of R1's Norco 5/325 the evening of 7/6/2024 at 3:00 P.M., 7:00 P.M. and 10:45 P.M. V5 added that between change of shift on 7/6 and 7/7/2024, it was only the three of us (V3 and V4, V5) that have the access for the narcotic box where (R1's) Norco was placed. It was identified by (V4) that (R1's) Norco 5/325 mg. tablets and the Norco narcotic count sheet form were missing. This was identified during the narcotic count sheet between (V3) and (V4). I believe (V3) took (R1's) Norco but she said she does not know. How could (V3) not know if (V3) was the only one who had the access to the narcotic box prior to being noted it was missing. V5 also said that she did not administer Norco medication to R1 on 7/6 and 7/7 of 2024 during the day shift. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/2024 at 2:00 P.M., V4 said that she was routinely scheduled to the dementia unit and was assigned to R1 during the night shift. V4 said she was scheduled night shift on 7/6 and 7/7 of 2024. V4 said that during the change of shift with V3 on 7/6 at 11:00 P.M., both counted R1's Norco tablets in the narcotic box. V4 said they both counted the Norco tablets and checked with the Norco narcotic count sheet. V4 said there were approximately 7 tablets of Norco. V4 said she had noticed that R1's narcotic count sheet showed that V3 signed off indicating that she took R1's Norco 3 tablets at 3:00 P.M., 7:00 P.M. and 10:45 P.M. V4 said that she was well aware of R1's routine of taking Norco which was only once a day and was usually given early morning. V4 said it was very unusual that (V3) took 3 tablets of Norco) from (R1) based on the narcotic count sheet. This was very unusual that (R1) had Norco every 4 hours. (R1) was only having daily Norco and was comfortable with a pain patch only. V4 said that during the narcotic count at the change of shift on 7/7/2024 at 11:45 P.M. with V3, V4 noted that R1's Norco tablets and Norco narcotic count sheet were both missing. V4 said she had asked V3 what happened to R1's Norco tablets and the narcotic count sheet. V4 said that V3 kept saying follow your policy, I don't know, I don't know what happened. V4 said she immediately called V2 (Assistant Director of Nursing) due to missing controlled medication. V4 said (V3) might deny that she took the Norco, but she was the only one who had the access to the narcotic box and no one else, so how would she not know what happened to (R1's) Norco. Obviously, she took (R1's) Norco since she was the only responsible staff for that specific narcotic box during her shift. It was already strange the day before when (V5) and I have noticed that (V3) signed off from (R1's) Norco narcotic count sheet indicating she took 3 Norco tablets on 7/6/2024. On 7/16/2024 at 11:24 P.M. V2 said that she had received a call from V4 on 7/7/2024 at around 11:45-11:50 P.M. V2 said that V4 had reported to her that R1's Norco tablets and Norco narcotic count sheet were missing which V4 discovered during the narcotic count with (V3) during the change of shift. V2 said that she immediately called V1 (Administrator), and she had started asking the assigned nurses that took care of R1 (V4 and V5). V2 said that V3 left the building and did not answer her phone despite multiple attempts from V2 to contact her. V2 said that finally with staffing agency's help, V3 had called the facility on 7/9/2024 and said that (V3) kept saying I don't know, I don't know. V2 added that based on interviews, and V3's response it tells a lot without saying anything.