| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145511 | A. Building<br>B. Wing | 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bella Terra Lombard | 2100 South Finley Road<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410<br><br>Based on observation, interview, and record review, the facility failed to provide timely incontinent care to dependent residents.<br><br>This applies to 2 of 4 residents (R4 and R5) reviewed for activities of daily (ADL) care in a sample of 5.<br><br>The Findings Include:<br><br>1. R4 is an [AGE] year-old female admitted on [DATE] with cognition intact as per the Minimum Data Set (MDS) dated [DATE]. MDS also documents that R4 is dependent on toilet hygiene.<br><br>On 3/7/25 at 10:05 AM, R4 stated, They changed me this morning at around 4:30 AM. I want to be changed now. The CNA is supposed to come and change me.<br><br>On 3/7/25 at 10:10 AM, V5 (CNA) stated, I started 6:00 AM today and am on my way to change R4. We should provide incontinent care to dependent residents every two hours. I was passing breakfast trays.<br><br>On 3/7/25 at 10:10 AM, R4 was observed with a urine-soaked incontinent brief with brownish discoloration.<br><br>A review of R4's incontinent care plan documented that the staff checks the resident for incontinent episodes every two hours and as needed and assists the resident in washing, rinsing, and drying her perineum.<br><br>2. R5 is an [AGE] year-old female admitted on [DATE] with cognition severely impaired as per the MDS dated [DATE]. MDS also documents that R5 is dependent on toilet hygiene.<br><br>On 3/7/25 at 10:15 AM, R5 was observed in her bed with her daughter (V9) at the bedside. On 3/7/25 at 10:15 AM, observed V6 (CNA) checking on R5 for incontinence and observed R5 with urine and feces-soaked brief, with dark brown discoloration. V6 stated that R5 is not her resident and she is just helping out another aide.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145511 | A. Building<br>B. Wing | 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bella Terra Lombard | 2100 South Finley Road<br>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.

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of R5's incontinent care plan documented that the staff checks the resident for incontinent episodes every two hours and as needed and assists the resident in washing, rinsing, and drying her perineum.<br><br>On 3/7/25 at 10:20 AM, V2 (Director of Nursing/DON) stated that the staff should provide incontinent care to residents every two hours and as needed. Moisture Associated Skin Dermatitis (MASD) is developed due to prolonged exposure to moister/urine.<br><br>The facility presented incontinent, and the Perineal Care policy was revised on 7/31/24 document:<br><br>Procedures:<br><br>1. Do rounds at least every 2 hours to check for incontinence during the shift. |

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|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410<br><br>Based on observation, interview, and record review, the facility failed to follow the physician orders to provide wound care to a stage 4 sacral pressure ulcer. This applies to 1 of 3 (R1) residents reviewed for pressure ulcer and treatment in a sample of 4.<br><br>The findings include:<br><br>R1 is an [AGE] year-old male admitted on [DATE] with severe cognitive impairment as per the minimum data set (MDS) dated [DATE].<br><br>A review of the admission summary note dated 12/31/24 documents that R1 was admitted with an unstageable sacral wound (16.0 x 10.0 x 4.0 centimeter/cm) along with both heels and right knee wounds.<br><br>The wound assessment report dated 3/6/25 by V7 (Wound Care Nurse Practitioner/NP) documented a stage 4 wound with 100% granulation (15.0 x 12.0 x 3.0 cm).<br><br>On 3/7/25 at 9:40 AM, observed V3 (Wound Care Nurse) and V4 (Certified Nursing Assistant) providing wound care to R1's sacral wound. V3 stated that R1 came back from the hospital two days ago after the wound was debrided.<br><br>On 3/7/25 at 9:40 AM, during wound care, R1's sacral wound was observed to have moderate drainage, and V3 cleansed the wound with saline-sprayed gauze instead of irrigating the wound. The wound was packed with hydrogel-moistened gauze instead of calcium alginate.<br><br>Record review on Physician Order Sheet (POS) documented a wound care order for sacrum wound: Irrigate with normal saline (NS), apply Cavilon barrier spray to the peri-wound area, lightly pack with hydrogel-moistened kerlix, cover with 2 abdominal pads, and secure with tape.<br><br>Record review on wound assessment report dated 3/6/25 by V7 documented treatment plan with calcium alginate to the base of the wound.<br><br>On 3/7/25 at 10:20 AM, V2 (Director of Nursing/DON) stated that V3 should have irrigated the sacral wound and packed it with calcium alginate, as recommended by the wound nurse practitioner.<br><br>On 3/7/25 at 9:45 AM, V3 stated that she didn't have individual saline vials to irrigate the wound, and she used barrier film wipes instead of Cavilon spray as she didn't have that spray.<br><br>On 3/7/25 at 1:55 PM, V7 stated, I made my wound round with the wound care nurse (V3) yesterday morning, and at that time, I mentioned V3 to use calcium alginate packing as the wound was draining moderate to heavy. Calcium alginate is used to absorb exudate and thereby enhance wound healing. I also recommended calcium alginate packing in my late entry note from yesterday at 7:00 PM. I can't enter my orders into the system as I am from an outside agency. The wound care nurse should have entered the calcium alginate order under the physician's name and packed the wound with calcium alginate. If the physician's (MD) order says to irrigate the wound, they should irrigate the wound as per the MD's order. |