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	10/06/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility staff failed to promptly report a resident's allegation of abuse to the facility's abuse coordinator in accordance with facility policy. This applies to 1 of 3 residents (R1) reviewed for abuse allegation.The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including type 2 diabetes, closed fracture of the left lower leg, chronic diastolic congestive heart failure, legally blind, personal history of malignant neoplasm of the breast, hearing loss, and acquired absence of uterus and cervix, added to diagnoses on September 23, 2025. R1's MDS (Minimum Data Set) dated July 14, 2025, showed R1 was moderately cognitively impaired and required assistance with ADLs including, set up assistance with eating, substantial assistance for turning side to side in bed, and dependent on staff for oral hygiene, bathing, dressing, toileting, personal hygiene, and transfer. R1 had a care plan initiated on February 11, 2025, for the behavior of resisting ADL care due to misunderstanding caregiver requests, that could result in resistance or combative behavior. The interventions to address this concern included: emphasize soothing, kind, slow and compassionate speech when speaking to R1, do not rush or hurry her, use body language that communicates patience and understanding. On October 1, 2025, at 2:45 PM, R1 stated on Sunday evening (September 28, 2025) at 8:00 PM, V10 (CNA) while providing incontinence care, grabbed her left wrist and would not let go when R1 asked her to. R1 stated she was experiencing pain in her abdomen during the care, due to her recent abdominal surgery and she was trying to use her left arm to assist the CNAs reposition herself but V10 kept holding onto her left arm and would not let go when R1 asked her to. R1 stated she swatted at V10 with her right arm so V10 would let go of R1's left wrist. R1 stated she knew it was V10, because she recognized V10's voice and stated V10 is softspoken and R1 often had a hard time hearing V10 when she speaks. R1 stated she told V4 (RN) on the next morning September 29, 2025, when V4 asked R1 how her weekend was. On October 1, 2025, at 1:26 PM, V4 (RN) stated she was R1's nurse on September 29, 2025, during the 7:00 AM and 3:00 PM shift. V4 stated she asked R1 how her weekend was during her morning greeting and R1 told that R1 was rushed through ADL care over the weekend. V4 did not report the allegation to the abuse coordinator. V4 stated she reported the allegation to her supervisor, V3 (ADON, Assistant Director of Nursing).On October 1, 2025, at 1:37 PM, V3 (ADON) stated V4 had reported that R1 alleged she had been rushed through care. V3 stated when she spoke to V2 (Director of Nursing, DON) later in the afternoon, V2 had told V3 that R1's POA (Power of Attorney) made an allegation regarding R1 being rushed during care. On October 1, 2025, at 4:30PM, V9 (Assistant Administrator) stated V2 (DON) reported on September 29, 2025, around 3:00 PM, she received an allegation from R1's POA on a voicemail message. V9 stated V1 (Administrator) was also present when V2 reported the allegation. V9 stated she interviewed R1 and was told that R1 alleged R1 was rushed during ADL care but did not specify when or who had rushed her care. V9 stated based on her interview with R1, V9 determined R1 made an allegation of mental abuse and made an initial report to IDPH and initiated the investigation. V9 stated neither V3 or V4 reported R1's allegation to V9 or V1 when R1 had reported it in the morning. On October 2, 2025, at 1:29 PM, V10 (CNA) stated she was the assigned CNA for R1 on September 28, 2025, 2PM-10 PM shift. V10 stated she responded to R1's call light around 8:00 PM , and R1 requested assistance with incontinence care. V10 stated she gave R1 care for incontinence, assisted by V11 (Agency CNA). V10 stated she was standing on the right side of R1's bed and V11 was on the left side. V10 stated while R1 was lying on her left side, after V10 completed cleaning R1, the clean linens were placed under R1. V10 stated she did hold R1's left hand/wrist to try and assist R1 to turn to the right so the linens could be straightened out underneath R1. V10 stated R1 told V10 to let go of her hand, but V10 did not and continued to try and pull R1 to the right, holding on to R1 left hand/wrist. V10 stated she knew R1 well and knew she did not like to feel rushed through care. V10 stated V11 was able to pull the linens from underneath R1 with R1 only being partially on her right side. V10 stated R1 hit her with her right hand while she was holding R1's left hand. V10 stated she did not report that R1 had hit her until she was interviewed on October 1, 2025. V10 stated she did receive a message from V9 on Monday September 29, 2025, in the late afternoon but did not return the call. V10 stated she worked the next day on September 30, 2025, on the 2PM - 10PM shift on R1's unit and stated neither V9 nor any management staff interviewed her or requested to talk to her during that shift.On October 2, 2025, at 2:05 PM, V11 (Agency CNA) stated she assisted V10 to provide incontinence care to R1 on September 28, 2025, 2PM-10PM shift