

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Bella Terra Lombard		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy to obtain measurements of a pressure injury during a wound evaluation. This applies to 1 of 3 residents (R1) reviewed for pressure injuries in the sample of 6. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including rheumatoid arthritis, chronic kidney disease, congestive heart failure, pressure-induced deep tissue damage of right buttock, unstageable pressure ulcer of sacral region, and unstageable pressure ulcer of left buttock. R1's skin integrity care plan dated January 13, 2026, [R1] has an actual impairment to skin integrity related to sacral and bilateral buttock wound unstageable pressure ulcer. The care plan continued to show multiple interventions dated January 13, 2026, including Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician. On January 27, 2026, at 10:43 AM, V3 (Wound Nurse) said she assesses newly admitted residents for skin impairments with 24 hours of admission. V3 said if she is unsure how to measure the wound then she will wait for the next time the wound nurse practitioner comes to that facility. V3 said she did not measure R1's buttock pressure injuries and she is unsure why she did not measure R1's pressure injuries on her buttocks. V3 said sometimes she does not measure pressure injuries because she does not want to measure incorrectly and measure the pressure injury as larger than it is. A Skin/Wound Evaluation dated January 14, 2026, at 5:01 PM, by V3 showed R1 had a suspected deep tissue injury to the bilateral buttocks. The documentation does not show measurements of R1's bilateral buttock pressure injury. A Nursing-Admission/readmission assessment dated [DATE], at 3:57 PM, did not show measurements of R1's bilateral buttocks pressure injuries. A wound assessment report dated January 19, 2026, by V16 (Wound Nurse Practitioner) showed Date of Service: January 16, 2026. Wound 2, Location: Left glute, Primary Etiology: Pressure Ulcer/Injury, Stage/Severity: DTI (Deep Tissue Injury), Wound Status: Present on admission, Size: 6.7 cm (centimeters) by 3.9 cm by 0 cm. Calculated area is 26.13 square cm. Wound Base: 100% (percent) epithelial, Periwound: Intact, Fragile. Wound 3, Location: Right glute, Primary Etiology: Pressure Ulcer/Injury, Stage/Severity: DTI, Wound Status: Present on Admission, Size: 9.3 cm by 5.3 cm by 0 cm. Calculated area is 49.29 square cm, Wound Base: 100% epithelial, Wound Edges: Attached, Periwound: Intact, fragile. On January 27, 2026, at 3:12 PM, V2 (Director of Nursing) said when a resident is admitted to the facility, the admitting nurse will assess the resident for wounds and document what they see. V2 said V3 then comes within 24 hours to assess the resident's skin. V2 said she would think as a nurse, the pressure injuries should be measured when being assessed. V2 said without admission wound measurements, V2 cannot say if a wound had gotten larger between the time the resident was admitted to the facility and when the wound nurse practitioner comes in to assess the resident. V2 said staff should follow the policy for wound care guidelines. The facility's policy titled Wound Care Guidelines dated January 24, 2025, showed Overview of the Program: This</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145511
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility adheres to the Federal and State regulatory requirements for wound care management and the care guidelines for wound care established by the National Pressure Injury Advisory Panel. The goal of this care guidelines is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in the facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure injuries and the purpose of the treatment focused recommendations is to provide evidence-based guidance on the most effective strategies to promote pressure injury/ulcer healing. Procedures: .11. Wound assessment for pressure, diabetic, venous, and arterial wounds: Wound assessment documentation shall include but are not limited to: type of wound and/or ulcer, etiology, location, date, stage, (if applicable), length, width, and depth; wound bed description, wound edge description and if present, exudates, undermining, tunneling, and wound related pain.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's bed had protective pieces in place for the resident's safety. This applies to 1 of 3 residents (R1) reviewed for resident injury in the sample of 6. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including rheumatoid arthritis, chronic kidney disease, congestive heart failure, pressure-induced deep tissue damage of right buttock, unstageable pressure ulcer of sacral region, and unstageable pressure ulcer of left buttock. R1's ADLs (Activities of Daily Living) care plan dated January 14, 2026, showed [R1] has an ADL self-care performance deficit requiring assistance in completing daily needs related to impaired mobility, pain. The care plan continued to show multiple interventions dated January 14, 2026, including Transfer: [R1] requires partial staff assist with sit to stand, chair-bed-to-chair transfer and max staff participation with toilet transfers. On January 28, 2026, at 10:18 AM, V14 (CNA/Certified Nursing Assistant) said she gave R1 a shower on January 19, 2026, and R1 wanted to be transferred back to bed immediately after her shower. V14 said she transferred R1 back to bed and noticed some redness on R1's left lower leg. V14 said she inspected the shower chair and R1's bed for the cause. V14 said she saw there were some square pieces on the middle of the bed frame which were missing the plastic protective pieces. A Skin Alteration Nursing Evaluation dated January 19, 2026, at 8:15 PM, by V15 (RN/Registered Nurse) showed R1 had a rear left lower leg skin tear. On January 27, 2026, at 1:16 PM, V7 (Admissions Director) said he had heard from V9 (Social Services Director) a resident's bed needed to be replaced due to missing plastic protective pieces. V7 said the bed was changed and is now in the basement. On January 27, 2026, at 1:20 PM, V8 (Maintenance Assistant) said the resident's bed was missing two plastic protective pieces located in the center of the bed frame. V8 showed the resident bed with the missing pieces. The bed frame had exposed metal squares with no plastic covering over the metal. On January 27, 2026, at 1:35 PM, V9 said he had a care plan meeting with R1's daughter on January 20, 2026. V9 said at the meeting, R1's daughter said there were missing pieces on R1's bed and R1 scratched her leg on the bed. V9 said he notified V7 of the issue with R1's bed. On January 27, 2026, at 2:53 PM, V1 (Administrator) said a resident's bed should have all the required pieces to ensure the resident's safety.</p>		