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	06/25/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent the development of a facility acquired stage 3 pressure ulcer. This failure resulted in R1 developing a facility-acquired stage 3 sacral pressure ulcer. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in sample 5. The findings include:1.The EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including Type 2 diabetes, multiple sclerosis, hypertension, gastroesophageal reflux disease, low back pain, difficulty in walking, unsteadiness on feet and dementia. The MDS (Minimum Data Set), dated May 11, 2026, showed R1 was cognitively impaired and dependent on staff for toileting, hygiene, bathing and transfers. The MDS continued to show her skin was intact on admission. R1's care plan dated May 11, 2026, showed she had a potential for skin impairment. The care plan said she will continue to have skin intact, and interventions included to keep skin clean and dry turn and reposition at least every two hours and as needed.R1's Skin and Wound note dated May 15, 2026, by V14 (Wound Care Nurse Practitioner) showed on admission, skin was overall intact. Prior sacral ulcer was healed. Plan to continue routine skin assessments, monitor for any signs of breakdown. R1's Nursing admission assessment dated [DATE], showed no existing pressure ulcer.On June 24, 2026, at 11:01 AM, V9 (family member) stated she visited R1 on June 9, 2026, and observed that R1 appeared uncomfortable and complained of pain. V9 also stated she turned R1 to assess her skin and observed two sores on R1 sacrum area V9 further stated she immediately notified V17 (RN/Registered Nurse) that R1 was in pain and showed V17 the wounds. V9 stated V17 assessed the area and asked the CNA (Certified Nursing Assistant) to provide incontinence care and apply a barrier cream and stated that staff were unaware of the sores until she brought them to the nurse's attention.On June 25, 2026, at 11:28 AM, V17 (RN/Registered Nurse) stated that while she was sitting at the nursing station on June 9, 2026, V9 told her R1 was complaining of pain. V17 stated she immediately went to R1's room and assessed the sacral area and observed an open area with no dressing present. V17 stated she instructed the CNA to provide incontinence care and apply barrier cream V17 stated she notified the nursing supervisor who contacted the physician to obtain treatment orders. V17's progress note dated June 9, 2026, showed writer was notified by the resident's family that the resident complained of pain in the buttocks area. Upon assessing the resident, I observed what appeared to be a pressure related wound, possibly related to moisture. The CNA changed the resident and applied a barrier cream. I informed the nurse supervisor, who then notified the medical doctor. Follow up with wound care arranged to ensure ongoing treatment. will endorse the oncoming nurse to follow-up.On June 24, 2026, at 2:16 PM, V13 (CNA/Certified Nursing Assistant) stated she provided care to R1 on June 10, 2026. V13 stated she took R1 to her room to provide incontinence care and observed an skin impairment area on R1's sacral region. V13 stated she immediately reported the findings to the nurse. V13 stated the nurse advised her she would come assess the wound. V13 stated she completed R1's incontinence care and returned R1 to the dining room. V13 stated the nurse did not assess the wound while she was providing care. V13 further stated there was no dressing covering the wound at that time.On June 24, 2026, at 11:58 AM, R1 was sitting in her wheelchair. V16 (CNA/ Certified Nurse Assistant) wheeled R1 to her room. V3 (Wound care (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 B. Wing	06/25/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nurses/WCNs) said R1 has a stage 3 pressure ulcer on her sacral area. V3 (WCN) removed R1's silicone boarder gauze dressing to assess the wound. R1's sacrum wound bed had approximately 10% slough, 50% granulation and 40% epithelial. V3 said R1's wound was last assessed and measured on June 24, 2026, by V14. V3 said she performs the wound dressing changes daily and the floor nurses perform any as needed daily dressing changes. V3 cleaned R1's wound with normal saline and gauze. V3 said the wound measured 1.2 cm (length) (centimeter) x 1 cm (width) x 0.1 (depth). V3 applied medi honey, calcium alginate and covered with silicone boarder gauze.On June 24, 2026, at 1:10PM, V3 (WCN) stated she was unsure of the exact date the wound reopened but believed it was around June 10, 2026. V3 stated she received a message regarding the wound during the evening and assessed the wound the following day. V3 stated R1's skin was intact upon admission to the facility. V3 stated that when she first assessed the open pressure ulcer on June 10, 2026, it was covered with slough and appeared as a cluster of two areas. V3 stated that R1 does not stand or walk independently and requires staff assistance with ADLs (activities of daily living). V3 stated R1 was previously continent of bowel and bladder but now requires staff assistance with incontinence care. V3's progress note dated June 12, 2026, showed Resident has been monitored since Wednesday for a suspected wound to the sacral area. During today's assessment, the nurse practitioner identified a Stage 3 pressure ulcer located on the sacrum in an area of previous scar tissue. The wound measures 3.0 cm x 1.3 cm x 0.2cm and presents as a cluster.On June 25, 2026, at 10:35 AM, V14 (Wound NP/Nurse Practitioner) stated the sacral wound reopened but was unsure how long the wound had been present before it was identified. V14 stated that because R1 had a previous open area prior to admission the skin in that area was more fragile and required ongoing monitoring. V14 stated R1 was at an increased risk for skin breakdown due to impaired mobility. V14 stated prolonged pressure to the sacral area and immobility contributed to the development of stage 3 pressure ulcer. V14 stated earlier identification of the wound would have prevented its progression to a stage 3 pressure ulcer. V14 stated it is her expectations that nursing staff perform routine skin assessments, provide timely incontinence care and reposition residents in accordance with the residence care plan. The facility does not have documentation to show that R1 was repositioned every 2 hours per the facility care plan interventions.On June 25, 2026, at 2:40 PM, V2 (DON/Director of Nursing) stated she became aware of R1's wound after V3 (WCN) notified her during wound rounds. V2 stated V3 informed her that the wound had reopened. V2 stated that she was unaware of who initially identified and reported the wound. V2 also stated nursing staff are expected to monitor residents skin during shower days and when completing full body assessments and to immediately report any changes in skin integrity to the wound care team so appropriate interventions can be implemented.The facility's policy titled Wound Care Guidelines dated January 24, 2024, stated the goal of this care guideline 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. Under the subheading of Prevention of skin breakdown included inspection of skin every shift with care for signs of breakdown, keeping local areas of skin clean and dry and free of body waste, perspiration and wound drainage. Under the subheading of Activity, Mobility and Positioning included while in bed resident should be repositioned at least every two hours or as indicated in the care plan. Under the subheading of Skin Protection included assess and treat incontinence. As part of incontinent care, apply protective ointments.