

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra Bloomingdale		STREET ADDRESS, CITY, STATE, ZIP CODE 165 South Bloomingdale Road Bloomingdale, IL 60108	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 48944</p> <p>Based on observation, interview, and record review, the facility failed to report a Resident fall (caused by an improper transfer) to licensed staff before assisting the Resident up from the floor, failed to transfer residents using gait belts, and failed to ensure resident transfer status was clearly communicated.</p> <p>This applies to 5 out of 5 residents (R1-R5) reviewed for accidents.</p> <p>The findings include:</p> <p>1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including post-operative care for a lumbar L3-5 transforaminal spinal fusion surgery with complications of wound infection and dehiscence, spinal stenosis of the lumbar region with neurogenic claudication, neuropathy, abnormalities of gait and mobility, difficulty walking, and unsteadiness on feet. R1's MDS (Minimum Data Set) dated 11/30/2024 showed R1 was dependent on staff for toilet transfers.</p> <p>R1's hospital records dated 12/12/2024 said The patient .presents with right leg pain and numbness which has worsened since she was dropped while being assisted to the toilet at the SNF [facility] on 12/11/2024. Since then, she has had worsening back pain and radiculopathy to the bottom of her right foot. The sensation is diminished to the right leg from L3 down. R1's hospital records said R1 received treatment for acute on chronic pain.</p> <p>On 12/17/2024 V3 (Agency Certified Nurse Assistant/CNA) was unable to be reached for an interview. V3's facility witness statement dated 12/12/2024 regarding R1's fall said CNA stated that she was transferring Resident in the bathroom sometime after dinner and Resident lost her balance, so she lowered her to the floor. Transferred via 1 person assist. CNA doesn't remember if she notified the nurse .Requested help from another CNA to assist patient off the floor.</p> <p>On 12/17/2024 at 2:30 PM, V13 (CNA) said on 12/11/2024 after dinner, V3 called him into R1's bathroom for assistance. V13 said R1 was on the floor in a sitting position in front of the toilet with one leg extended forward and another with her knee bent underneath her buttocks. V13 said they then proceeded to lift R1 by placing their arms underneath her armpits to transfer her onto the toilet. V13 said he couldn't recall if a gait belt was used. V13 said he informed V3 that R1's transfer status was a sit-to-stand machine with a 2-person assist.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/17/2024 at 2:35 PM, V4 (Agency Registered Nurse/RN) said she took care of R1 on 12/11/2024 on the evening shift (3 PM-11 PM) and night shift (11 PM-7 AM). V4 said she did not assess R1 after her fall because V3 (Agency CNA) did not inform her of the incident. V4 said R1 started to complain of knee pain at 3 AM (12/12/2024). V4 said R1 then informed her she had fallen on the prior shift because V3 had failed to use the sit-to-stand equipment when transferring R1 to the toilet. V4 said she administered pain medication to R1 and tried to notify R1's physician.</p> <p>V4's Progress Note dated 12/12/2024 at 2:32 AM said, I was told that the patient fell in the pm shift, and the incident was not reported to me until now. No one was informed about the fall. The patient stated that her knee hurt and rated her pain 8 on a scale of 0-10. R1's EMR shows on 12/12/2024 at 4:23 AM she received Oxycodone HCl 5 mg (milligrams) by mouth for severe pain.</p> <p>On 12/17/2024 at 12:45 PM, V9 (RN) said she then re-assessed R1 on 12/12/2024 at 9 AM because R1 was now having acute pain in her back and legs, which was unrelieved with her pain medication. V9 said she notified R1's physician, and R1 was transferred to the hospital.</p> <p>V9's Progress Note dated 12/12/2024 at 9:57 AM showed, Resident complaining of back pain and bilateral leg pain, as needed pain medication was given but still ineffective. Resident verbalized that she would want to be sent to ER.</p> <p>On 12/17/2024 at 11:00 AM, V10 (Therapy Director) said R1 was receiving therapy services because she was very weak after undergoing a complex surgery on her lumbar spine. V10 said therapy had recommended R1's transfer status to be a sit-to-stand machine with a 2-person assist. V10 said therapy notifies nursing of transfer recommendations to ensure they are followed and updated in the residents' plan of care. V10 said transfer status are recommended to ensure the safety of residents and prevention of falls.</p> <p>On 12/17/2024 at 11:20 AM, V11 (Restorative Nurse) said restorative and therapy assess residents' transfer status during admission, quarterly, annually, or if there is a significant change. V11 said restorative nursing completes Resident's Care Profiles document when a resident is admitted and if there is a change in transfer status. V11 said Resident Care Profiles are located in each Resident's room to ensure nursing staff is aware of how to safely transfer residents.</p> <p>R1's Physical Therapy notes dated 12/12/2024 said R1 was at risk for falls. The notes said R1 was dependent for toilet transfers. R1's Restorative Section GG: Admission form dated 11/25/2024 showed R1's toilet transfer (the ability to get on and off a toilet or commode) was also dependent. R1's Restorative UDAs form dated 11/23/2024 showed Transfer Status a. Mechanical sit to stand lift with 2 or more person assist.</p> <p>R1's undated Resident's Care Profile said, R1's transfers were substantial/maximal and number of staff to assist: 1. The Resident's Care Profile did not show the transfer device of sit-to-stand was selected for R1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/17/2024 at 1:50 AM, V2 (Director of Nursing/DON) said she was still investigating R1's 12/11/2024 fall incident because her fall was not reported and an incident report was not completed. V2 said she expected all fall incidents to be reported immediately to ensure the Resident is being properly assessed and safely transferred after a fall incident. V2 also said she expects Resident's Care Profile transfers to be updated and followed to ensure safe residents' transfers. V2 said she was unsure why R1's Resident's Care Profile transfer was not accurate to include R1's need for a sit-to-stand machine with a 2-person assist.</p> <p>The facility's policy titled Restorative Nursing Program dated 8/19/2024, said It is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission .may include .b. Transfer .Nursing and restorative services shall be reflected in the resident's individualized care plan consistent to the completion of the resident comprehensive assessment .Resident assistance with ADLs will be based on the above functional assessment.</p> <p>The facility's 8/16/2024 Notification for Change of Condition policy showed The facility will provide care to Resident and provide notification of resident change in status .a. An accident involving the Resident which results in injury and has the potential for requiring physician intervention . b. A significant change in the Resident's physical, mental, or psychosocial status .</p> <p>2. On 12/17/2024 at 9:35 AM, R2 was using the toilet. At 9:44 AM, R2 called for assistance, and V8 (RN) responded and said she would assist R2 in getting off the toilet. V8 did not use a transfer gait belt and instead pushed up on R2's mid-lower back to assist her to a standing position. R2 was able to only use her left hand to hold on to the rail for support because her right arm was flaccid and her fingers were contracted. V8 stood behind R2 while providing pericare, then R2 started to slightly squat back, and V8 used her upper leg to help support R2 to maintain her balance. V8 then pulled up R2's pants and used the back waist of her pants to guide her into a sitting position in her wheelchair.</p> <p>On 12/17/2024 at 11:00 AM, V10 (Therapy Director) said gait belts should be always used for residents who require 1 or 2-person transfer assistance with transfers. V10 said gait belts are used for safety to help provide residents with standing support during transfers and help prevent falls.</p> <p>R2's care plan reviewed on 12/17/2024, said [R2] is high risk for falls related to Gait problem, such as unsteady gait, even with mobility aide or personal assistance, slow gait, takes small steps, takes rapid steps or lurching gait. The care plan had multiple interventions including I would like staff to provide me a safe environment. R2's undated Resident's Care Profile said, R2's transfers were substantial/maximal and required the device use of a gait belt.</p> <p>On 12/17/2024 at 1:50 AM, V2 (Director of Nursing/DON) said she expected nursing staff to use gait belts when performing transfers to help residents maintain balance and guide them during the transfer process. V2 said staff should not be pulling on Resident's pants or pushing up on their backs to bring them to a standing or sitting position.</p> <p>The facility's policy titled Gait Belt dated 7/26/2024, said The facility will use gait or transfer belts to assist residents needing limited to total assistance during transfers and walking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 12/17/2024 at 9:50 AM, R3 self-transferred to the toilet without supervision. V7 (CNA) was not supervising R3 because she was stripping R3's bed linen. V7 then went to assist R3 with dressing while she was sitting on the toilet. V7 said she had stepped out of the room to get wash towels and left R3 unsupervised sitting on the toilet. V7 then returned and instructed R3 to stand and pushed up on R3's mid-lower back to assist her in a standing position. V7 did not use a transfer gait belt. V7 stood behind R3 to provide pericare and then pulled up her pants. V7 then used the back waist of R3's pants to guide her into a sitting position in her wheelchair. V7 said she reviews the Resident's Care Profiles in the residents' closets to know their transfer status.</p> <p>R3's care plan reviewed on 12/17/2024, [R3] is at risk for falls related to: Specific: Current medication use, Poor safety awareness, Unsteady gait . The care plan had multiple interventions including Provide DME (durable medical equipment) if needed. R3's undated Resident's Care Profile showed R3's transfers were substantial/maximal and required the device use of a gait belt.</p> <p>4. On 12/17/2024 at 10:15 AM, R4 called for assistance to be transferred from the bed to the toilet. R4 said she required the use of a sit-to-stand machine for transfers. At 10:45 AM, V5 (CNA) and V6 (CNA) used the sit-to-stand machine to transfer R4 out of bed into the toilet. They said they review the Resident's Care Profiles in the residents' closets to know their transfer status. They then reviewed R4's Resident's Care Profile and said it did not indicate R4 was a sit-to-stand transfer. They said R4 had been declining and was at risk for falls and that's why they had been using a sit-to-stand machine to transfer her.</p> <p>R4's undated Resident's Care Profile said, R4's transfers were substantial/maximal and number of staff to assist: 1. The Resident's Care Profile did not show the transfer device of sit-to-stand was selected for R4.</p> <p>5. On 12/17/2024 at 10:50 AM, R5 said she just received a shower and was transferred back into bed with the use of a sit-to-stand machine. R5 continued to say that sometimes nursing staff also uses the sliding board to transfer her out of bed. V7 (CNA) said she had just transferred R5 using a sit-to-stand because she was transferred into the shower chair, but they also transferred her using a sliding board when assisting her out of bed.</p> <p>R5's undated Resident's Care Profile said, R5's transfers were substantial/maximal and number of staff to assist: 2 with the use of a sliding board device. The Resident's Care Profile did not show the transfer device of sit-to-stand was selected for R5.</p> <p>On 12/17/2024 at 11:00 AM, V10 (Therapy Director) said she was familiar with R4 and R5 because they had recently received therapy services. V10 said R4 was treated after a fall and was discharged with a 1-staff assist transfer status recommendation on 11/8/2024. V10 said R5 was also treated and discharged last week with a recommended transfer status of a sliding board with a 2-staff assist. V10 said therapy did not make any recommendations for sit-to-stand transfers for R4 and R5.</p> <p>On 12/18/2024 at 12:40 PM, V2 (DON) confirmed that nursing staff had been transferring R4 into her recliner geriatric chair with the use of the sit-to-stand machine and R5 also when transferring into the shower chair. V2 said she was unsure why R4 and R5's specific transfer instructions of when to use the sit-to-stand device were not indicated in their Resident's Care Profiles.</p> <p>The facility said they did not have a Transfer policy or a Resident's Care Profile policy.</p>		