STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145638	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Bloomingdale	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)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain timely diagnostic imaging. This applies to 1 of 3 residents (R1) reviewed for diagnostic imaging in the sample of 7. The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including hydronephrosis, hypertension, type 2 diabetes mellitus, diabetic foot ulcer, venous insufficiency, and congestive heart failure. R1's Order Listing Report showed an order dated February 6, 2026, for Right duplex scan, veins, extremity, unilateral/limited study. Sent for imaging February 6, 2026. One time only related to venous insufficiency. R1's Radiology Results Report dated February 13, 2026, at 5:33 PM, showed Examination Date: February 9, 2026. Reported Dated February 13, 2026, 5:33 PM. On March 24, 2026, at 3:12 PM, V2 (DON/Director of Nursing) said the facility did not receive R1's diagnostic imaging results until February 13, 2026. V2 said she reached out to the diagnostic imaging company following R1's care plan meeting on February 13, 2026, when R1's family questioned about the results of R1's diagnostic imaging. On March 25, 2025, at 2:37 PM, V12 (Radiology Company Liaison) said the radiology company received R1's order for a right duplex on February 6, 2026, the imaging was completed on February 9, 2026, and the results were sent to the facility on February 13, 2026. V12 said on February 13, 2026, the facility reached out to V12 inquiring about the results. V12 said she had to speak with the radiology doctor group to ensure they had the test because the test had not been read by a radiologist yet. V12 said the radiology company's contract with the facility shows a diagnostic imaging test should be completed within 24 hours of the test being ordered. V12 said a test results are usually available within six to eight hours and the company does quality control checks daily but this exam was missed. On March 25, 2026, at 2:56 PM, V13 (Radiology Company Territory Manager) said R1's duplex was delayed three days and the radiology company should have contacted the facility to make them aware and set up a date. V13 said there was not any communication between the facility and the radiology company regarding R1's delayed exam. V13 said per the contract, if it was going to take longer than 24 hours to conduct the exam, the facility should have been informed of when the exam could be performed. V13 said he does not know why it took so long for the exam to be resulted. V13 said that is insane it took four days to get results. The facility does not have documentation to show communication between the radiology company and the facility occurred regarding the delay in R1's right duplex being performed or the delay in receiving R1's right duplex results. The Facility Agreement between the radiology company and the facility dated November 1, 2025, showed .2. Duties and Obligations of Provider. b. Provider shall provide services within 24 business hours or schedule a time for the services. The Provider will promptly notify the Facility if services time is unable to be met.

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