STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145678	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Schaumburg	675 South Roselle Road Schaumburg, IL 60193

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 head of the bed was upright during meals (R9). This applies to 1 of 5 residents reviewed for safety in the sample of 47. The facility also failed to ensure a second-floor medication cart was locked when unsupervised. The findings include: 1. R9's face sheet printed on 1/15/26 showed diagnoses including but not limited to brain cancer, palliative care, heart disease, skin cancer, and protein-calorie malnutrition. R9's facility assessment dated [DATE] showed supervision needed for eating and on a mechanically altered diet. R9's dietary evaluation dated 12/26/25 showed dysphagia (difficulty swallowing) and dental problems of broken or fractured teeth. On 1/13/26 at 12:58 PM, R9 was lying in bed during the lunch meal service. R9 had a plate of mechanical soft food directly in front of him on the over the bed table. The meal consisted of diced carrots, pasta, and a roll. R9 had black, broken teeth in his upper mouth and missing teeth on the bottom. R9's head of the bed was declined, and he was trying to spoon food into his mouth. The room divider curtain around the bed was pulled and R9 was not visible from the hall. At 1:15 PM, R9 was still in the same position with the head of the bed declined. At 1:16 PM, V24 (CNA-Certified Nurse Aide) stated room trays get delivered to resident rooms around 12:45 PM daily. At 1:30 PM, V25 (second CNA) entered R9's room and could be heard raising the head of the bed. V25 confirmed R9 was still eating and exited the room. This surveyor entered the room and R9 was still feeding himself. On 1/15/26 at 10:55 AM, V20 and V21 (Wound Care Nurses) performed care on R9. During care V20 and V21 stated R9 does eat by himself in bed. He needs to be in an upright position, not flat. He is on a mechanical soft diet because he has dental issues and is at risk for aspiration. The head of the bed should be up to prevent choking on food. On 1/15/26 at 12:31 PM, V3 (Director of Nurses) stated R9 should have the head of the bed upright as tolerated but at least at 45 degrees or so during meals. Nothing less. He could aspirate or choke if it is any lower. R9's care plan showed a focus area initiated 4/9/25 related to compromised nutritional status due to a diagnosis of dysphagia. Goals included no episodes of choking or aspiration. Interventions included assess the resident during mealtime, utilizing safe swallowing technique and protocols. 2. On 1/15/26 at 7:40 AM, upon arrival to the second floor, the medication cart was located down the hallway outside of a resident room. The medication cart was unlocked. There was no staff present in (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the hallway or near the cart. This writer waited by the cart for staff to arrive. V16 Licensed Practical Nurse (LPN) stepped out of a resident room and immediately locked the cart. She said the cart should have been locked when she stepped away. On 1/15/26 at 12:12 PM, V2 (Assistant Administrator) said the medication cart should be locked whenever staff step away. They should be locking it for safety so no one can get into it. The daily census of 1/13/26 documents the second floor to have 62 residents. The facility's 7/2/25 policy for medication storage, labeling, and disposal documents 3. Medications will be stored safely under appropriate environmental controls. 4. Medications will be secured in locked storage area.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were offered bedtime snacks for 5 of 5 residents (R21, R83, R88, R100, and R118) reviewed for snacks in the sample of 47. The findings include:On 1/14/26 at 10:39 AM, During the group resident meeting all 5 residents present (R21, R83, R88, R100, and R118) stated they do not receive and are not offered bedtime snacks. R21's face sheet showed she was admitted to the facility 10/02/2019. R21's facility assessment dated [DATE] showed she has no cognitive impairment. On 1/14/26 at 10:29 AM, R21 said she is the Resident Council President. R21 said she can't even get an extra cookie or dinner dessert treat to take back to her room to eat later. R21 said she has asked staff if she could have something to take back to her room and they tell her no. R118's face sheet showed he was admitted to the facility 7/16/24. R118's facility assessment dated [DATE] showed he is cognitively intact. R118 said, That is a BIG NO. R83's face sheet showed she was admitted to the facility 7/22/25. R83's facility assessment dated [DATE] showed she has no cognitive impairments. R88's face sheet showed he was admitted to the facility 9/5/24. R88's facility assessment dated [DATE] showed he has no cognitive impairments. R100's face sheet showed he was admitted to the facility 12/23/23. R100's facility assessment dated [DATE] showed he has no cognitive impairment. On 1/15/2026 at 12:42 PM, V19 (Dietary Manager) said snacks are provided only to the resident's who the dietitian tells them to. V19 said they have a list of people who get snacks, and they get delivered to the nursing station on each floor labeled with the resident name and room number. V19 said no other residents are offered snacks and there is nothing available to send up if they were to ask for it at bedtime. The facility's policy and procedure revised 6/26/25 showed, Bedtime (HS) Snacks. Policy Statement: the facility will provide the residents bedtime snacks in accordance with the federal regulations. Procedures: The facility must offer snacks at bedtime daily.The facility's policy and procedure reviewed 9/12/21 showed, Resident Food and Nutrition Services Standard Operating Procedures Manual. Policy Statement: Between meal snack/nourishments shall be made available for residents 3 times/day to ensure residents are provided adequate nourishment and hydration between meals. Snacks/ Nourishments will be provided at the following times. AM (morning) Snack. PM (afternoon) Snack. HS (bedtime) snack. All residents will be offered a snack/nourishment unless otherwise indicated in his/her plan of care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review the facility failed to ensure medical records were private for 1 of 1 resident (R105) reviewed for privacy in the sample of 47.The findings include:On 1/15/26 at 7:40 AM, upon arrival to the second floor, the medication cart was located down the hallway outside of a resident room. The cart had a computer mounted on top of the cart. The computer screen was open to R105's medications. There was no staff in the hall or near the cart. This writer waited by the cart for staff to arrive. V16 Licensed Practical Nurse (LPN) stepped out of a resident room, and said she was called away to a resident room, but the screen should have been closed.On 1/15/26 at 12:12 PM, V2 Director of Nursing said when a nurse steps away from her cart the computer should be closed and no resident information exposed. That would be a HIPAA (Health Insurance Portability and Accountability Act) violation.The facility's 12/8/25 policy for Notice of privacy practices states 1. The resident has a right to secure and confidential personal and medical records. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, electronic, or other.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff thoroughly cleaned a resident who was dependent on staff for incontinent care for 1 of 1 resident (R159) reviewed for activities of daily living (ADLs) in the sample of 47.The findings include:R159's admission Record, provided by the facility on 1/15/26, showed she had diagnoses including, but not limited to, dementia, osteoarthritis, diverticulosis of small intestine, pressure ulcer of sacral region, acute kidney failure, urine retention, and altered mental status. R159's facility assessment dated [DATE], showed she has severe cognitive impairment and is dependent on staff for all cares. R159's skin impairment care plan initiated on 11/13/25, showed she remains at high risk for skin breakdown due to a history of multiple pressure injuries. The care plan showed one of the interventions in place was Keep skin clean and dry. R159's ADL care plan initiated on 11/20/25, showed she has an ADL self-care performance deficit and is dependent on staff for her toileting and personal hygiene needs.On 1/15/26 at 10:20 AM, V20 (Wound Nurse in training/RN) and V21 (Wound Nurse/LPN) donned PPE (Personal Protective Equipment) and went in to do the wound care for R159. V21 said R159 had pressure ulcers on admission that were very large and were healed about two weeks prior to this observation. V20 said they are monitoring the areas and applying barrier cream to R159's buttocks. R159 was positioned on her left side and V20 undid R159's brief and pulled it down. R159 had been incontinent of stool. V20 grabbed the wipes and cleaned the stool from 159's buttocks area. This surveyor could see visible stool in R159's perineum area that was not cleaned. V20 removed the gloves used for incontinent care, performed hand hygiene and donned new gloves. V20 applied barrier cream to R159's buttocks and a new brief was placed on R159. V20 and V21 repositioned R159 and started placing pillows under her to offload areas of pressure. V20 had put the wet wipes back in the drawer. This surveyor asked them to please check R159's front area to make sure all the stool was cleaned off. After undoing the brief, V20 grabbed the wipes out of the drawer and wiped R159's vaginal and perineal area. Visible stool was on the wipe. The brief that was put on after incontinent care also had visible stool on it. V20 used two more wipes, and each one had visible stool on it. R159 was rolled onto her right side and V21 said she was going to make sure they got all the stool off. V21 used three wipes, one at a time and they all had visible stool on them. V21 said it is important to make sure all the stool is cleaned off of the residents when giving care to prevent infection and skin breakdown.On 1/15/26 at 10:50 AM, V3 (Director of Nursing-DON) said it is important to make sure staff are cleaning all the stool from a resident while providing care to prevent infection and skin breakdown. The facility's policy and procedure titled Incontinence and Perineal Care, with a revision date of 6/30/2025, showed it is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review the facility failed to prevent, identify, initiate a treatment, and notify the physician of a new skin condition for 1 of 2 residents (R140) reviewed for non-pressure skin conditions in the sample of 47. The findings include:R140's face sheet showed she was admitted to the facility 3/27/23 with diagnoses to include senile degeneration of brain, hypokalemia, hypertensive heart and chronic kidney disease without heart failure, dementia without behavioral disturbance, generalized anxiety disorder, insomnia, and overactive bladder. R140's facility assessment showed dated 12/23/25 showed she had severe cognitive impairment and dependent upon staff for all cares. R140's current Physician Order Sheet showed no orders for treatment or monitoring in place of her bilateral shins.On 1/13/26 at 1:30 PM, R140 was in her room sitting up in her wheelchair. V26 (R140's son-in-law) was present in the room with R140. R140's shins were exposed. R140 had several dark bruises on each shin and steri-strips had been applied to an area on each shin. Drainage could be visualized under the steri-strips on both of R140's shins. V6 said, Those bruises and the steri-strips has been on and off like this for months, she has had bruising or skin tears in various forms for months. R140's care plan initiated 3/27/23 showed, [R140] has potential for alteration in skin integrity related to needs assist with personal care, incontinent of bowel and bladder and extensive assist with bed mobility. Diagnosis of reduced mobility, weakness, cognitive communication deficit, dementia, hyperlipidemia. HIGH RISK -Skin check every shift. Report abnormalities to the nurse. On 1/15/26 at 9:20 AM, V20 (Wound Care Nurse) said she was not aware of R140 having any skin conditions. V20 said residents have falls sometimes and maybe the skin tears occurred from a fall and the nurses put the steri-strips on. V20 said these skin conditions could have just happened today. V20 said R140 is a hospice patient so maybe hospice placed the steri-strips. V20 said the facility staff and the hospice staff should let her know when there is a new skin condition. V20 looked at R140's shins with the surveyor and said, It doesn't even look like anything. Maybe they put the steri-strips over the bruises. V20 said steri-strips are not typically a treatment for bruising but usually used for skin tears. V20 used an alcohol swab and wiped over the steri-strips to R140's left shin. The steri-strips peeled up and there was dried blood visualized on R140's shin and on the steri-strips. V20 said, See there is nothing there. R140 did not remove the steri-strips to R140's right shin. V20 said when a new skin condition is reported to her, she would come assess the area, notify the wound care company, enter orders for treatment and monitoring, and there would be an investigation started to determine the cause of the skin condition. V20 said the resident's care plan would also be updated. On 1/15/26 at 9:30 AM, V12 (Nursing Supervisor) said she was not aware of R140's skin conditions. On 1/15/2026 at 1:34 PM, V3 DON (Director of Nursing) said, when staff notice a skin alteration they should report it to the nurse right away. V3 said the facility has a wound care nurse in the facility 7 days a week and the wound care staff should be notified. V3 said she would expect that the staff would assess the wound, open a skin/wound assessment in the electronic record, notify the doctor and the family, and make sure that there is a treatment in place. V3 said it is important to complete these steps because they don't want the wound to get worse, they want to make sure the proper interventions are in place, and it is important for the doctor to be able to determine the appropriate treatment. V3 said an investigation would be initiated to determine what caused the area and if there needs to be staff training done or other interventions put into place to prevent it from happening again. The facility's policy and procedure with review date of 7/3/25 showed, Skin Care Regimen and Treatment Formulary. Policy Statement: It is the policy of this facility to ensure prompt identification, documentation and obtain appropriate treatment for residents with skin breakdown. Procedures: 1. Charge nurses must document in the Electronic Health Record any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained from the patient's physician. Treatment Protocol: . a. Skin Tears/Laceration: Film dressing (ex: Tegaderm), foam dressing. Xeroform gauze and topical antibiotic unless contraindicated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an insulin pen was disinfected prior to attaching the needle for 1 of 1 resident (R108) reviewed for insulin injections in the sample of 47.The findings include:R108's admission Record, provided by the facility on 1/15/2026, showed she had diagnoses including, but not limited to, dementia and type II diabetes mellitus. R108's Order Summary Report, printed 1/15/2026, showed the following active order for Humalog Kwik pen Subcutaneous Solution Pen Injector 100 units/ml. inject per sliding scale before meals and at bedtime. R108's facility assessment dated [DATE], showed she has severe cognitive impairment and requires substantial/maximal assist from staff, or is dependent on staff for all cares except eating. R108's careplan initiated on 11/7/2025, showed she is at risk for fluctuating blood sugars due to diabetes mellitus. The care plan showed the nurse should administer sliding scale per physician's order.On 01/14/2026 at 11:23 AM, V6 (Registered Nurse-RN) checked R108's blood sugar level and informed R108 she was going to get her insulin ready and be right back. When preparing the insulin, V6 removed the cap from the Humulog Injector Pen and attached the needle without disinfecting the rubber top at the end of the pen prior to attaching the needle. V6 administered the insulin to R108. V6 was asked if the rubber end of the injector pen needs to be disinfected prior to attaching the needle. V6 said she does not need to alcohol the end of the insulin pen prior to attaching the needle.On 01/14/2026 at 2:42 PM, V14 (Licensed Practical Nurse-LPN) said the nurse's do not need to alcohol the top of insulin pens before attaching the needle.On 01/15/2026 at 9:08 AM, V28 (First floor Nurse Manager) said the insulin pens should be disinfected with alcohol wipes before attaching the needle to the end of the pen for infection control.On 1/15/2026 at 10:50 AM, V3 (Director of Nursing-DON) said the nurses should alcohol the rubber end of the insulin pen before attaching the needle for infection control.The facility's policy and procedure titled Medication Pass, with a revision date of 7/2/2025, did not address disinfecting insulin injector pens prior to attaching needle, nor did it mention disinfecting the rubber stopper on insulin vials prior to inserting the needle.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide incontinent care in a manner to prevent cross contamination (R45, R159) and failed to ensure staff wore the personal protective equipment (PPE) required when accessing a resident's intravenous line (R2) for 3 of 3 residents (R45, R159, R2) reviewed for infection control in the sample of 47.The findings include:1. R45's admission Record, provided by the facility on 1/15/2026, showed she has diagnoses including, but not limited to, early onset Alzheimer's disease, acute kidney failure, urine retention, major depressive disorder, and anxiety disorder. R45's facility assessment dated [DATE], showed she has moderate cognitive impairment. The assessment showed R45 is always incontinent of bowel and bladder and is dependent on staff for toileting hygiene and personal hygiene. R45's care plan initiated on 3/3/2024 showed she is dependent on staff for toilet hygiene. R45's care plan initiated on 5/18/2024 showed she was at risk for skin breakdown relating to needing assist with personal cares, and being incontinent of bowel and bladder, among other health concerns. On 1/13/2026 at 12:29 PM, R45 said she turned her light on because she is wet, and needs changed. V23 (Restorative Aide) and V27 (Certified Nursing Assistant-CNA) came in to provide incontinent care for R45. V23 and V27 removed R45's incontinent brief. The brief was soiled with urine. V27 grabbed several wipes and stacked together and wiped R45's pubic area, then right groin area, then down R45's middle vaginal area with the same wipes. V27 did not use a different section of the wipes or fold the wipes. V23 and V27 put a clean brief on R45 and assisted her with repositioning. On 1/15/2026 at 9:08 AM, V28 (First floor Unit Manager) said wet wipes should be discarded after each swipe and a clean wipe should be used when cleaning the vaginal area to prevent infection. For infection control. On 1/15/2026 at 10:50 AM, V3 (Director of Nursing-DON) said staff should use a clean wipe with every swipe. Using the same wipe to clean the resident's pubic area, groin, then vaginal area can cause an infection because that is an opening to the body. 2. R159's admission Record, provided by the facility on 1/15/2026, showed she had diagnoses including, but not limited to, dementia, osteoarthritis, diverticulosis of small intestine, pressure ulcer of sacral region, acute kidney failure, urine retention, and altered mental status. R159's facility assessment dated [DATE], showed she has severe cognitive impairment and is dependent on staff for all cares. R159's ADL care plan initiated on 11/20/2025, showed she has an ADL self-care performance deficit and is dependent on staff for her toileting and personal hygiene needs. On 1/15/2026 at 10:20 AM, V20 (Wound Nurse in training/RN) and V21 (Wound Nurse/LPN) donned PPE and went in to do the wound care for R159. R159 had been incontinent of stool. While providing care, V21 tossed three wet wipes visibly soiled with stool over the bed to try to make it into the trash can on the other side of the bed. Every time, the wet wipes landed on the floor instead of the bed. After incontinent and wound care was done, V20 picked the three soiled wet wipes off the floor and placed them in the trash bag. V20 lifted the trash bag out of the can to tie it off. While doing this, V20 was standing right over the area the soiled wipes had just been. On 1/15/26 at 10:50 AM, V3 (Director of Nursing-DON) said V21 should not have tossed the soiled wet wipes over the bed to put in trash. The trash can should be next to the staff cleaning the resident so they could just put it in the trash can. For infection control and to prevent cross-contamination. V3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said staff should use a clean wipe with every swipe. Using the same wipe to clean the resident's pubic area, groin, then vaginal area can cause an infection because that is an opening to the body. The facility's policy and procedure titled Incontinence and Perineal Care, with a revision date of 6/30/2025, showed It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. The procedure showed.5. Maintain clean techniques. 6. Wash the perineal area and gently dry after the procedure. 7. Discard disposable items into designated containers/plastic bag. 3. R2's Care Plan showed R2 requires Enhanced Barrier Preauction (EBP) related to IV (intravenous) medications. This care plan intervention was initiated on 12/10/25 On 1/13/26 at 11:24 AM, V13 Registered Nurse entered R2's room to administer R2's IV antibiotic. During the process of administering the IV medication, V13's clothing brushed up against R2's bedding. V13 was not wearing a gown. Posted outside V13's door was a sign showing she was in Enhanced Barrier Precautions, and a gown was required for device care or use: central line, urinary catheter, feeding tube, tracheostomy. On 1/13/26 at 12:40 PM, V13 stated she should have worn a gown when accessing the IV to prevent the spread of any protentional contamination. On 1/14/26 at 2:24 PM, V2 Director of Nursing stated enhanced barrier precautions is required for IV access. V2 stated the gown is an extra barrier of protection to prevent the spread of contamination. The facility's Enhanced Barrier Precaution policy (revised 9/16/25) showed EBP involves the use of gown and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents.with wounds and/or indwelling medical devices. The policy showed a gown is required during high contact resident care.