STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145701	A. Building B. Wing	09/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Streamwood	815 East Irving Park Road Streamwood, IL 60107

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to provide residents weekly showers for two of three residents (R2 and R3) reviewed for showers in the sample 11. Findings include: The facility's Shower and Hygiene Policy dated 8/19/24 documents, It is the policy of this facility to ensure that resident showers/hygienic care is provided by the nursing staff to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin. Administer resident shower once weekly and/or as often as necessary. Documentation: Date and shift the shower was performed. The name/title of the nursing staff who assisted the resident with the shower/bath. 1. R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 needed staff assistance for hygiene and showers. R2's Shower/Bathing and Skin Monitoring Report dated 6/29/24 (Admission) through 7/31/24 documents R2 only received two showers within this timeframe on 7/10/24 and 7/27/24. On 9/20/24 at 4:40 PM V4 (R2's Family Member) stated, (R2) no longer resides at the facility. Whenever I would visit (R2) he was dirty, and his hair was greasy. (R2) was not getting showers. 49187 2. R3 was readmitted from the (Local Hospital) on 9/4/24. R3's MDS dated [DATE], documents R4 has a memory problem, is moderately impaired for daily decision making, is unable to ambulate, and requires maximum to dependent staff assistance with ADL's (Activities of Daily Living). R3's Shower/Bathing and Skin Monitoring Report dated 9/4/24 through 9/19/24 documents R3 only received one shower within this timeframe on 9/16/24. On 9/20/24 at 8:45 AM R3 was lying in bed. R3 did not respond to verbal stimuli. R3's hair was unkempt and all R3's fingernails were long, jagged, and had brown matter underneath. R3 was still in a facility gown and had a putrid smell. (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
	145701	A. Building B. Wing	09/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Streamwood	815 East Irving Park Road Streamwood, IL 60107

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/24 at 9:30 AM V17 (Certified Nursing Assistant) verified R3's long nails with black matter underneath them. V17 stated, I am getting ready to give (R3) a bed bath now and I will clip and clean her nails. On 9/2/204 at 2:00 PM V2 (Director of Nursing) verified R2 and R3 (according to shower reports) did not receive at least one shower per week. V2 stated, According to facility policy they should at least receive one shower per week. The staff should also be clipping and cleaning residents' fingernails on shower days at least.