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	03/20/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** 34516 Based on interview and record review, the facility failed to supervise a resident at high risk for falls during patient care by leaving the resident alone for staff to obtain supplies and then finding the resident on the ground. The facility failed to train staff on identifying residents at risk for falls. The facility also failed to implement measures to prevent falls from happening. These failures affect 1 (R9) of 4 residents reviewed for falls in the sample of 45. These failures resulted in R9 being emergently transferred to the hospital and admitted with a left femur fracture that required surgical intervention. Findings include: R9 is an [AGE] year-old with diagnoses including but not limited to dementia, heart failure, severe morbid obesity, absence of right leg above knee amputation, and oblique fracture of left femur. Hospital records dated 3/7/25 titled Operative Reports authored by V10 (Surgeon) reads in part, Patient is obtunded and confused. Alert and oriented x 2. Notes reflect that she fell in facility 3/2/25. Had pain in the left thigh last couple of days when admitted and x-rays to left femur demonstrate distal third femoral shaft fracture. She recently had an AKA (Above Knee Amputation) on the right side, so she needed her left side to transfer to wheelchairs therefore decision was made to undergo open reduction intramedullary nailing of the left femur. On 3/18/25 at 10:25 AM, V5 (Fall and Psychotropic Nurse) stated that she had completed R9's fall investigation and conducted the interviews to get root cause of the fall. V5 indicated that during her internal investigation, she was told by V6 (Certified Nursing Assistant/CNA) that she was in the room with the resident and was told V7 (Agency Nurse) that R9's colostomy was leaking, so she went there to check and told the CNA she was going to get the supplies. While waiting for the nurse, R9 was allegedly lying flat on her bed when V6 (CNA) went to get extra linens right outside the room. V6 went to get the linens and left the resident on the bed. Surveyor asked V5 whether the CNA in question left the resident unattended. V5 stated, Yes, but she wasn't left unattended very long. Surveyor asked if she witnessed this incident to know the length of time the resident was left alone. V5 stated, No, this happened around midnight. Surveyor asked what the CNA should have done when caring for a high fall risk such as R9. V5 stated, V6 (CNA) should have prepared the supplies prior to propping the resident up to clean her and not leave her unattended. (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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(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 - Actual harm Residents Affected - Few	On 3/18/25 at 10:40 AM, V6 (CNA) stated, I started working at the facility about 3 weeks ago, so I did not know the resident (R9). I was making rounds, and she was sitting up in bed and the bed was already raised up and her gown had feces on it from her colostomy bag, so I went to clean her up and laid the bed flat. I went to reach for my pad to clean her so I can change the beddings and then I heard her scream. I was at the doorway reaching for a pad and I rushed back into the room and found her on the floor. Surveyor asked that if she had to rush back to the room would imply, she left the room to begin with. V6 responded, But the cart was just outside the doorway. Surveyor asked if there was any sort of padding the resident may have fallen on to cushion her fall. V6 replied, No, there was nothing under her. Her head was at the foot of the bed slightly under the bed. Surveyor clarified how she was able to reach for supplies without leaving the resident unattended. V6 stated, My linen cart was in the hall outside the door, but you can say I left her unattended, but it was very fast. Surveyor asked if she knew anything about the resident prior to working with her. V6 said, I know she is alert, and she can ask for things, but I was not told anything about her. When I got hired, I oriented for 3 days but on all floors each day. Surveyor asked if she was aware that R9 recently had a leg amputation. V6 stated, No. They said she just got back from the hospital the day before. Surveyor asked whether she knew R9 was at high risk for falls. V6 stated, When I was working with her, I was not familiar with her at all, and no one told me whether she was a fall risk or not. No one told me anything about her at all. On 3/18/25 at 10:50 AM, V7 (Agency Nurse) stated, I've worked here (referring to the facility) about a dozen times, and I float. When I worked with (R9), it was probably the second or third time. The night of her fall, I had just come in for my shift 11 PM to 7 AM and I was doing rounds and replacing oxygen humidifiers on various rooms, and I went into R9's room and found V6 (CNA) there trying to clean the resident's colostomy, but it needed to be replaced. I looked to see if there were any colostomy bags in the room but there weren't any so I told V6 to finish cleaning R9 up and that I'd be back with a new colostomy bag after finishing my rounds and replacing humidifiers. When I was about finished with my rounds, I heard the call light buzzing and it was R9's room. When I got into the room the resident was on the floor at the foot of the bed with her head under the footboard part and both legs were facing outward. Surveyor clarified if she was certain of her description as R9 had only one leg, V7 stated, Yes, she had her legs extended facing the window and her head was slightly under the bed. I asked V6 what happened, and she told me she had to get supplies to clean the resident. Surveyor asked if she was given formal training by the facility about fall prevention. V7 stated, I wouldn't call it formal training, but they provided orientation packet to take home and that was last year. Surveyor asked if she received any endorsement from the previous nurse about R9's current condition or risk for falls. V7 stated, I did not get any endorsement about R9 or that she came back with an amputated knee. I just knew she recently got back from the hospital, but I didn't know for what. On 3/18/25 at 12:02 PM, R57 (roommate of R9) said that she heard R9 screaming on the ground but did not see the resident fall. R57 stated, I was awakened around midnight when (R9) was screaming loudly. I pulled the call light so someone would come in to help her. R57 said that she had seen V6 (CNA) come into the room to take the resident's gown off and saw the same CNA again when R9 started screaming. Minutes later, R57 indicated she saw the nurse V7 come in and then later saw paramedics take the resident out. Records show the R57's BIMS (Brief Interview for Mental Status) score of 15 showing her to be cognitively intact. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25 at 1:04, V12 (attending physician) stated that the facility called him when R9 fell so he gave the order to send the resident out and that she came back with a femur fracture. V12 stated, I don't follow the resident when they're admitted to the hospital. I was just informed by the facility about the fall which happened just days after the amputation of the right leg. They (the facility) told me she slid out of the bed and was found on the floor. (R9) is high risk for falls but she was already at risk prior to this latest fall with fracture. Surveyor asked if R9 required extra precautions due to her new amputation. V12 agreed and said that they should have taken extra precautions because she had dementia, severe morbid obesity, and was a recent leg amputee which made her more at risk and unstable (poor trunk control). R9's fall prevention care plan prior to her most recent fall of 3/2/2025 was revised last on 4/14/2023 and reads, (R9) is at risk for falls related to history of CVA, diagnosis of epilepsy, diabetes, peripheral vascular disease and overactive, osteoarthritis, psychotropic medication, and unsteady balance. Goal: Prevent further falls until next review. Interventions: Keep call light within reach when in bedroom or bathroom. Side rails up to prevent rolling out of bed. Skilled Rehabilitation Therapy evaluation and treatment as indicated. Use of Assistive device during ambulation to prevent falls. Post fall care plan dated 3/11/25 reads, (R9) is high risk for falls related to recent hospitalization with surgical intervention, right AKA (Above Knee Amputation), recent fall with fracture to left femur. Goal: R9 will not sustain serious injury through next review. R9 will be free of falls through next review. Interventions: I prefer to keep all needed items like water pitcher, tissue box, urinal, etc., within reach. I prefer to keep the bed in the low position for safety. I would like PT (physical therapy)/OT (occupational therapy) to evaluate and treat me as ordered to increase my strength and mobility and prevent further falls. Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. Facility fall prevention policy titled Know how to prevent Resident Falls reads in part, Frequent Rounding: Orient resident to the surroundings, Ensure resident is sitting properly in chair and/or bed at right height. Anticipate resident's needs. Place call light and frequently used items within reach. Assist with toileting needs, mobility, and ADL's. Pay close attention to residents at high risk for falls. They may have had an actual fall prior to admission or have a diagnosis that make them high risk for falls.