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	12/05/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor a resident's (R4) right to refuse medication by crushing the medication and putting it into the R4's food without R4 being aware for one out of three residents reviewed for resident rights in a total sample of eight. Findings Include: R4 has the following diagnosis: generalized anxiety disorder, auditory hallucinations, catatonic disorder, noncompliance with medical treatment, and paranoid schizophrenia. On 12/2/25 at 2:18PM, R4 was sitting alone at a table in the dining room participating in the scheduled activity. R4 requested to stay in the dining room for the interview. R4 was alert and oriented times three. R4 denied any issues with medications or medication regimen. When asked if the facility forces, R4 to take scheduled medications, R4 said, no. The surveyor then asked if R4 ever found medications crushed up in R4's food and R4 said, Yes, it happened one time. R4 stated it occurred sometime in October but was unable to give an exact date or even a date range. R4 reported it happened at the lunch meal. R4 stated one day R4's food tasted funny so R4 thought the staff put R4's medication in the food. R4 report R4 saw crushed pills in the food. R4 denied reporting this allegation to anyone at the facility but called R4's guardian and the police. R4 reported R4 refuses medications because R4 doesn't need them. When asked how this makes R4 feel, R4 stated it makes R4 angry because if R4 doesn't want to take a medication then R4 shouldn't have to take it. R4 denied any other concerns at the facility. On 12/3/25 at 12:46PM, V4 (Psychotropic Nurse) stated R4 is on psychotropic medication for a diagnosis of schizophrenia but has a behavior of refusing the medications. V4 reported R4 doesn't have a reason for refusing and staff will educate or will offer the medication again to R4 if R4 refuses. V4 stated the facility never expects nurses to crush the medication and put it in food if a resident refuses. V4 reported it is a resident's right to refuse a medication. On 12/3/25 at 1:21PM, V7 (Registered Nurse/RN) stated R4 has a habit of refusing medication so V7 will offer the medication again to R4 later in the shift. V7 denied ever putting crushed medications into R4's food. V7 reported R4 is alert but has a guardian since R4 has psych diagnoses. V7 stated R4 doesn't have any behaviors if R4 refuses the medication and V7 will call to update the guardian if R4 refuses the medication. On 12/3/25 at 2:44PM, V10 (R4's Guardian) stated on 10/14/25, V10 spoke with R4 on the phone and R4 alleged a nurse crushed medications and put it in R4's food after R4 refused the medication. V10 stated V10 then called V7 and V7 admitted to crushing all the scheduled medications the day before and putting them in R4's food. V10 stated V10 told V7 that if R4 refuses the medication then they shouldn't be given to R4. V10 reported V7 apologized and told V10 that it won't happen again. The surveyor then interviewed V7 (RN) on 12/3/25 at 3:03PM to clarify statement in the previous interview. The surveyor made V7 aware of V10 statements of V7 admitting to putting the medications in food. V7 then admitted to crushing medications and putting them in R4's breakfast on 10/13/25 or 10/14/25. V7 stated V7 doesn't like when R4 refuses the scheduled medication and V7 found a way to get R4 to still take the medication. V7 reported that morning R4 refused the medication when offered earlier so all morning medications were crushed and put into oatmeal. V7 denied being aware how much of the oatmeal R4 ate. V7 reported if a resident refuses a medication, then staff should offer the medication again at a later time. V7 stated V10 spoke with V7 on the phone about consent and V7 told V10 that V7 will not put medications in R4's food again. The surveyor asked V7 what the seven rights of medication pass are and V7 was able to name five rights that were the right person, route, meds, reason, and dosage. The surveyor asked if a resident should be aware of what they are taking at all times and V7 said, yes. On 12/3/25 at 3:17PM, V11 (Administrator) stated V11 didn't make any notes about V7 giving crushed medications in food because V11 didn't think of it that way. V11 reported the facility does not teach staff to put medications in resident food if they refuse. V11 stated V11 hasn't looked at the medication policy in a while so V11 was unaware of what the medication rights were but reported R4 has a right to refuse medication. On 12/3/25 at 3:43PM, V12 (Director of Nursing) stated the facility crushed medications and put them in R4's food one time in August after getting clearance from the guardian (The guardian was not V10 at that time), but it was only one time. V12 reported the guardian's instructions were to only put the medication in the food one time then allow R4 to refuse the medication if R4 does not want to take them. V12 stated the facility cannot force a resident to take medications if they refuse. V12 reported R4 is alert and oriented but is delusional. V12 denied being aware of R4 being given any medication in food in October. On 12/3/25 at 4:03PM, V7 (RN) stated V7 called the guardian in August to get clearance to put the medication in the food then but it was only for one time. V7