

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2025
NAME OF PROVIDER OR SUPPLIER Bella Terra Streamwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent and protect (R4) from physical abuse out of 7 residents reviewed for abuse. Findings include: 1. Facility reported incident (FRI) submitted 11/07/2025 documents: R3 threw a shoe at R4 and hit him in the back of the head. R3 admitted to throwing the shoe at R4 because R3 was upset with R4. R3 is a 72 -year-old resident admitted to the facility on [DATE] with the diagnoses including but not limited to cerebral infarction, myocardial infarction, genitive deficit, diabetes, and subarachnoid hemorrhage, and cognitive functions and awareness. On the MDS (Minimal Data Set) assessment of 12/05/2025, Section C, the BIMS (Brief Interviewed Mental Status) score was 10/15, indicating moderate cognitive impairment. R4 is a 69 -year-old resident admitted to the facility on [DATE] with the diagnoses including but not limited to impulsive disorder, personality disorder, cognitive communication deficit, benign neoplasm of the pituitary gland, and dysphagia. On the MDS (Minimal Data Set) assessment of 11/04/2025, Section C, the BIMS (Brief Interviewed Mental Status) score was 15/15, indicating cognitive intact. On 12/20/25 at 11:50 AM, R3 said I got upset with R4 because R4 was accusing me of stealing potato chips from the cafeteria, but I did not do it. R4 was too loud, and I threw my rubber slipper at him and accidentally hit R4 over the head, and I did not have the intention of hurting him. I just wanted R4 to stop talking and accusing me of something I did not do. I did not get hurt, and I feel safe here. I have never done things like that before. On 12/20/25 at 11:25 AM, R4 said that I was in my room when R3 threw a shoe over my head and said that I was too loud, we never had any issue in the past and I called the staff and the staff removed R3 right away and brought R3 to the first floor and R3 is still there and I have not seen him since. I feel safe here, and I am not scared of anyone. On 12/20/25 at 1:36 PM called V8 (Registered Nurse), said, I worked on 11/07/25. I was not assigned to R3 and R4. I did not witness the incident. R3 and R4 did not have any behaviors that day and were not aggressive. They were good roommate together, and when I came back to work one day, I was told that R4 and R3 were separate and R3 is now on the first floor because R3 threw a shoe at R4's head. On 12/20/25 at 11:30 AM, V4 (Certified Nursing Assistant) said, I am familiar with R3 and R4, and I never seen them having any disagreement or fighting. I found out about the incident when I came back to work. On 12/21/2025 V7 (Registered Nurse) was the nurse for R3 and R4 on 11/07/25, the day of the incident. V7 is out of the country and unable to communicate at this time, but the V7 written interview stated that V7 did not witness any incident between R3 and R4. V7 interview said, he did not know about the incident until the police came, and he said he did not receive any complaints. On 12/21/2025 at 2:02 PM spoke with V1(Administrator) via telephone and said, I am very familiar with R1 and R2; both residents have no boundaries and will just say things that are hurtful to others. Care plan in place for the behaviors. We investigate and take any abuse allegation seriously, and I reported both incidents to the state surveying agency and completed a full investigation. The facility separated all the residents and made sure that they were not together. R1 and R2 are on totally different sides of the building, and R3 was moved to the first floor, and R4 remained in his room. We are doing more education for the staff. On 12/21/2025 at 2:00 PM, V3 (Director of Nursing) said, I am aware of the incident of R1, R2, R3, and R4, but V1 was the one who completed the investigation and can better provide details. All residents have behaviors documented under their care plan, and staff members are aware to monitor them and make sure that they redirect residents and report any behavior or abuse allegation. On 12/ 21/2025 at 2:00 PM, V3 (Director of Nursing) provided facility policy titled Abuse and Neglect, revised 06/26/25. Which reads in part (but not limited to), Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to presentation of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven federal components of prevention and investigation. Abuse is the willful infliction of mistreatment, injury, unreasonable confinement, intimidation, or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered. 1. Physical Abuse Physical Abuse includes, but not limited to infliction of injury that occurs other than by accidental means and requires medical attention. 2. Verbal Abuse Verbal Abuse includes, but is not limited to, the use of oral, written or gestural language. The definition includes communication that expresses disparaging and derogatory terms in language to residents within their hearing/seeing distance</p>		