

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra Elmhurst		STREET ADDRESS, CITY, STATE, ZIP CODE 420 West Butterfield Road Elmhurst, IL 60126	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on interview and record review the facility failed to follow its policy to immediately consult with a resident's physician and notify a resident's representative when a resident had a change in condition requiring resident to be transferred to the hospital.</p> <p>This applies to 2 of 6 residents (R1 and R2) reviewed for change in condition.</p> <p>The finding includes:</p> <p>1. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE] with multiple diagnoses including an encounter following surgery for a cardiac pacemaker, chronic atrial fibrillation, heart failure, pulmonary embolism, cerebrovascular disease, obstructive sleep apnea, and disorders of lungs. The EMR showed R2 was transferred to the hospital on 4/17/2024. R2's MDS (Minimum Data Set) dated 4/1/2024 shows R2 was cognitively intact and required staff assistance with her activities of daily living.</p> <p>On 4/24/2024 at 8:50 AM, V16 (Agency Registered Nurse/RN) stated she took care of R2 overnight on 4/16/2024. V16 stated R2 kept calling because she felt short of breath. V16 stated R2 was requesting oxygen, and she told R2 there was no order. V16 stated she checked R2's vital signs and told R2 she was not sure what was going on. V16 stated she tried to calm R2 and told her to try to sleep. V16 stated R2's daughter called at 7 AM on 4/17/2024 concerned. V16 stated she asked the incoming nurse V10 (Licensed Practical Nurse/LPN) to assess R2.</p> <p>On 4/23/2024 at 3:34 PM, V10 (LPN) stated on 4/17/2024 R2 told her she felt sick all night and she administered oxygen to R2 because she was short of breath. V10 stated R2 was then assessed by the NP (Nurse Practitioner) and was transferred to the hospital for shortness of breath.</p> <p>On 4/23/2024 at 2:07 PM, V12 (Nurse Practitioner/NP) stated she evaluated R2 on 4/17/2024 and gave orders for her to be transferred to the hospital because she was complaining of being short of breath and weak despite her diuretics recently being increased. V12 stated she would have expected the overnight nursing staff to have called the on-call physician or used the facility's telemedicine physician services to assess R2.</p> <p>The facility does not have documentation to show R2 was assessed overnight on 4/16/2024 by V16 (Agency RN) for shortness of breath nor a record of R2's oxygen saturation levels.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's hospital records dated 4/17/2024 showed R2 was hospitalized for shortness of breath and requiring the use of oxygen and was started on intravenous diuretics.</p> <p>2. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including craniotomy surgery, traumatic subdural hemorrhage with loss of consciousness, encephalopathy, history of falls, lack of coordination, physical debility, malnutrition, pressure ulcer to left heel, and bilateral hearing loss. The EMR showed R1 was discharged from the facility on 1/11/2024 to the hospital. R1's MDS (Minimum Data Set) dated 12/20/2023 shows R1 was cognitively impaired and was dependent on staff assistance with activities of daily living and transfers.</p> <p>On 4/24/2024 at 9:03 AM, V4 (R1's daughter) stated on 12/11/2023 around noon she went to the facility to have lunch with R1. V4 stated R1 was not at the facility and his personal belongings were packed. V4 stated she thought the worst. V4 stated V17 (Registered Nurse/RN) told her R1 was confused in the morning and was transferred to the hospital. V4 stated V17 apologized for not calling. V17 told her she got busy and did not call her. V4 stated she keeps track and saves all the calls on her phone. V4 stated R1 had a severe urinary tract infection and had to be hospitalized .</p> <p>On 4/24/2024 at 9:15 AM, V17 (RN) stated on 12/11/2023 around 8:30 AM she asked the nurse practitioner (NP) to assess R1 because she was concerned R1 was confused and restless. V17 stated the NP gave her an order to send R1 to the hospital. V17 stated she was busy and other staff were helping her and believes she called R1's daughter but did not leave a message or try calling her back. V17 said she then got busy with medication administration, and then V4 (R1's daughter) came to the facility. V17 said she then informed V4 of R1's change in condition and required transfer to the hospital. V17 said she apologized to V4 for not notifying her.</p> <p>R1's eINTERACT Transfer Form dated 12/11/2023, showed R1 did not have the decision-making capacity and required a proxy. The form did not show when R1's daughter was notified of the transfer.</p> <p>R1's hospital records dated 12/11/2023 showed R1 was in the ER (emergency room) being evaluated at approximately 10:20 AM and was admitted for acute encephalopathy possibly due to an infection.</p> <p>On 4/23/2024 at 4:00 PM, V2 (Director of Nursing/DON) stated she expected nurses to be alerted and further assess residents with a change in conditions, and update physicians and families.</p> <p>The facility's Notification for Change of Condition policy showed Policy Statement The facility will provide care to residents and provide notification of resident change in status. Procedures 1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: .b. A significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48944</p> <p>Based on interview and record review the facility failed to respond after being notified of a concern of missing items.</p> <p>This applies to 1 of 6 residents (R1) reviewed for grievances.</p> <p>The findings include:</p> <p>On 4/19/2024 at 12:50 PM, V4 (R1's daughter) stated she notified the facility on 1/7/2024 that R1's cell phone was missing. V4 stated she tried to use her phone locator application to locate the phone and V6 (Guest Service Director) and V13 (Medical Records Staff) tried to assist her, but the phone was not found. V4 stated on 1/11/2024 she asked the nurse on duty for R1's hearing aids that were stored in the nurse's medication cart for safekeeping, but they were not located. V4 stated she emailed V6 on 1/16/2024 for an update on the missing items and on 1/19/2024 V6 informed he would inform V1 (Administrator). V4 stated she continued to email V1 and V6 weekly, and on 2/16/2024 the facility told her they would reimburse her for the cell phone balance, but then they stopped responding to her emails. V4 stated she last emailed the facility on 3/26/2024 and became frustrated because the facility was not responding. V4 stated she called the facility's corporate complaint hotline on 4/16/2024 for further assistance and had not received a response.</p> <p>On 4/23/2024 at 1:48 PM, V6 (Guest Service Director) stated he tried to assist V4 in locating R1's missing cell phone, but they were not able to locate it and he notified V1 (Administrator).</p> <p>On 4/23/2024 at 3:24 PM, V1 stated he was notified of R1's missing items and did receive an email notification from the facility hotline about V4's concern. V1 stated he did not follow up with V4's concerns and was now getting corporate approval for the reimbursement and was planning to then notify V4. V1 stated the facility did not complete a grievance form for R1's missing cell phone or hearing aids because they wanted to find a resolution first.</p> <p>The email correspondences from V4 to the facility, showed a total of 71 days have passed without V4 receiving a resolution to her grievance.</p> <p>The facility's Grievance policy with reviewed date of 7/28/2023, showed Procedures .7. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. 8. If grievance is confirmed, the facility will take appropriate corrective action.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</p> <p>Based on interview and record review the facility failed to administer the ordered oxygen to a resident complaining of shortness of breath.</p> <p>This applies to 1 of 1 (R2) resident reviewed for respiratory care.</p> <p>The finding includes:</p> <p>R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE] with multiple diagnoses including an encounter following surgery for a cardiac pacemaker, chronic atrial fibrillation, heart failure, pulmonary embolism, cerebrovascular disease, obstructive sleep apnea, and disorders of lungs. The EMR showed R2 was transferred to the hospital on 4/17/2024. R2's MDS (Minimum Data Set) dated 4/1/2024 shows R2 was cognitively intact and required staff assistance with her activities of daily living.</p> <p>On 4/24/2024 at 9:00 AM, R2 was interviewed over the phone. R2 stated on 4/16/2024 around 7 PM she started to feel short of breath and needed oxygen. R2 stated V16 (Agency Registered Nurse/RN) told her she would give her oxygen but then told her something was missing. R2 stated V16 did not administer her oxygen throughout the shift, and she kept calling for help during the shift because she was scared and not feeling better. R2 stated she texted her daughter in the morning for help and her daughter called the facility. R2 stated the next shift nurse on 4/17/2024 at 7 AM administered her oxygen and she was then transferred to the hospital. R2 stated she was getting more diuretics and was feeling better now.</p> <p>On 4/24/2024 at 8:50 AM, V16 (Agency Registered Nurse/RN) stated she took care of R2 overnight on 4/16/2024. V16 stated R2 kept calling because she felt short of breath. V16 stated R2 was requesting oxygen, and she told R2 there was no order. V16 stated she checked R2's vital signs and told R2 she was not sure what was going on. V16 stated she tried to calm R2 and told her to try to sleep. V16 stated R2's daughter called at 7 AM on 4/17/2024 concerned. V16 stated she asked the incoming nurse V10 (Licensed Practical Nurse/LPN) to assess R2.</p> <p>On 4/23/2024 at 3:34 PM, V10 (LPN) stated on 4/17/2024 R2 told her she felt sick all night and she administered oxygen to R2 because she was short of breath. V16 stated R2 had a standing order for oxygen as needed. V16 stated R2 was then assessed by the NP (Nurse Practitioner) and was transferred to the hospital for shortness of breath.</p> <p>On 4/23/2024 at 12:07 AM, V11 (Unit Manager) stated she was familiar with R2 because she was being managed for heart failure and her diuretics were recently increased. V11 stated R2 was weaned off oxygen recently and had a standing for oxygen as needed.</p> <p>On 4/23/2024 at 4:00 PM, V2 (Director of Nursing/DON) stated she expected nurses to be alerted and further assess residents when needed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility does not have documentation to show R2 was assessed overnight on 4/16/2024 by V16 (Agency RN) for shortness of breath nor a record of R2's oxygen saturation levels or administration of oxygen.</p> <p>R2's care plan dated 4/24/2024 showed [R2] is at risk for alteration in respiratory functioning .interventions assess respiratory status: Observe for shortness of breath, check lung sounds, elevate head of bed, as needed .</p> <p>R2's Order Summary Report dated 4/23/2024 showed an order for Oxygen 2L/min via nasal cannula to maintain Oxygen Saturation level equal or above 92% as needed.</p>