Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145835	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Wheeling	730 West Hintz Road Wheeling, IL 60090

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 Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on interview and record review, the facility failed to treat a resident with respect and dignity by providing care in a discourteous manner. This failure applied to one (R3) of four residents reviewed for resident care. Findings include: R3 is a [AGE] year-old female admitted to the facility 05/01/23 with a diagnosis history of Anxiety, Autoimmune hemolytic anemia, CAD, Depression, Hepatitis B, Hypertension, A-fib, Interstitial lung disease, Neuropathy, Pneumonia, Diabetes type II D, Venous insufficiency, oftubularadenoma, cholecystectomy, radiofrequency ablation, colostomy, left total hip arthroplasty, breast biopsy, and Peg placement. On 06/03/24 at 12:05 PM, R3 said, I had a concern with one V9 (Certified Nursing Assistant) a couple weeks ago and I reported to the nurse and V12. I asked V9 to turn to my left side and change me. I did not want to turn towards the right side. V9 said, shit while providing care. I waited until V9 came in the next day to report the incident. I have not seen V9 here since the incident. R3 said, I don't feel comfortable and did not like it. It was disrespectful. On 06/03/24 at 12:12 PM, V12 (Family Member) said, I don't have concerns about the care and my mother never mentioned concerns with the care until I reported this. My mother reported that V9 used inappropriate language during care, and I reported it to the facility. On 06/03/24 at 03:45PM, V9 (CNA) said, I was providing care to the roommate, and I went to help R3. The facility started using a new brief and R3 did not like them. I put the brief on, and secured one side of the brief and the other side was torn. I asked R3 if there is a brief in the closet. R3 had the old briefs in the closet, and I changed R3 and said good night. I did not swear or use inappropriate language during the care. I was suspended during the investigation. I got a phone call on Saturday and stayed home. I have not provided care to R3 since the incident. On 06/04/24 at 1:00 PM, V2 (Director of Nursing) said, R3 is alert and oriented x2 and forgetful. R3 forgets receiving care and would call V12. R3 is seeking attention for V12 to come to the facility. V2 said, I never received complaints of V9, and I reported the incident. V9 said, that no inappropriate language was used during care. (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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Wheeling	730 West Hintz Road Wheeling, IL 60090

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/06/2024 at 09:33AM, V1 (Administrator) provided facility policy undated, Residents' Rights for People in Long-term Care facility, reads: You have the right to . Safety and good care- Your Facility must provide services to keep your physical and mental health and sense of satisfaction.