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 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Bella Terra Wheeling		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 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** 44103 Based on the interview and record review, the facility failed to provide appropriate assistive devices and staff supervision while walking to two cognitively impaired, high-risk falls residents (R1, R2) out of 3 residents reviewed for incidents/accidents. These failures resulted in R1 bumping R1's nose on the hallway countertop and sustained a nasal fracture. Findings Include: R1's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Unspecified Dementia Without Behavioral Disturbance, Unspecified Psychosis, History of Falling, and Altered Mental Status. R1's Minimum Data Set (MDS) dated [DATE] shows R1 has severe cognitive impairment and requires supervision or touching assistance with walking. R1's fall risk evaluation dated 9/09/24 shows R1 is at high risk for falls. This fall risk evaluation also shows R1 has unsteady gait, has memory problem, and is able to walk with assistance and/or assistive device. R1's restorative mobility evaluation dated 9/09/24 shows R1 uses a walker. R1's fall care plan initiated on 12/06/22 shows R1 is at risk for falls related to impaired balance, weakness, and activity intolerance. This care plan also shows that R1 is ambulatory and uses a rolling walker with cueing assistance. One of the fall interventions in the fall care plan reads in part, I have periods of forgetfulness. I would like staff to frequently reorient me to my surroundings (date initiated 12/06/22). R1's Activity of Daily Living (ADL) care plan date initiated on 11/30/22 shows R1 requires cueing to partial assistance with ADLs (transfers, walking), and R1 primarily utilizes a walker but oftentimes is forgetful to use a walker for ambulation; therefore, R1 is at risk for falls/injury. One of the interventions reads in part, Provide [R1] with reminders to use [R1's] walker, cue/assist if necessary (date initiated 9/09/24). (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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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The facility's final incident report sent to the state agency on 9/20/24 at 7:00 PM documents in part: On 9/13/24, at about 7:10 PM, [R1] was ambulating in the hall while holding hands with another female resident [R2]. The other resident began to fall, and as [R1] was still holding onto [R2's] hand, [R1] was pulled forward and bumped [R1's] nose on the hallway railing. [R1] did not fall or have a change in plane, [R1] was noted with swelling and skin tear measuring 0.2x0.5cm [centimeters] to the nose. Minimal bleeding noted. Abrasion was cleansed and covered with a band aid. Pain medication administered and ice pack applied. Neurochecks initiated. [V16 Advanced Practice Nurse] was notified with order to send to ED [Emergency Department] for evaluation. This report also documents that R1 was transferred to the acute hospital via emergency [911] where R1 was diagnosed with closed fracture of nasal bone and returned to the facility on [DATE] at 1:20 AM. R1's progress notes documented by V12 (Licensed Practical Nurse) indicates that per ER [emergency room] department, R1 has a bilateral nasal bone fracture and will return to the facility.

R1's hospital discharge instructions printed on 9/13/24 at 10:58 PM documents that R1's was seen for a fall and [R1] hit [R1's] nose with a diagnosis of Closed fracture of nasal bone, initial encounter.

R2's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Unsteadiness on Feet, Adult Failure to Thrive, Other Abnormalities of Gait and Mobility Unspecified Dementia Without Behavioral Disturbance, and History of Falling. R2's MDS dated [DATE] shows R2 has severe cognitive impairment and requires supervision or touching assistance with walking. R2's fall risk evaluation dated 8/16/24 shows R2 is high risk for fall. This fall risk evaluation also shows R2 has unsteady gait, has memory problem, is able to walk with assistance and/or assistive device, and just had a fall.

R2's fall care plan initiated on 6/11/22 documents in part: R2 is at high risk for falls related to a history of falls, behaviors, current medication use, poor safety awareness, unsteady gait, and disease process. R2 ambulates with use of walker with cueing and redirection from staff due to wandering behaviors. One of the fall interventions in the fall care plan reads in part, Assist [R2] with walking, remind [R2] of safety precautions as needed. May require frequent reminders and cuing of assistance requires for ambulation (date initiated 6/21/22). Another fall care plan intervention reads in part: Use of assistive device during ambulation to prevent falls (date initiated 6/11/22). R1's behavior care plan initiated on 6/16/22 documents in part: R2 exhibits poor safety awareness and will walk without R2's walker or regard to R2's own safety which increases R2's risk for falling and/or obtain an injury. One of the interventions reads in part, Provide frequent cues and redirection to wait for staff assistance (date initiated 6/16/22).

The facility's change in condition form for R2 dated 9/13/24 at 7:10 PM documents in part: R2 holding hands with another resident coming out of the room. The other resident tripped over [R2], and R2 sat down on the floor. Head to toe assessment done, no skin alteration noted, no injury. Vitals taken all within normal limits, denies pain. [R2] alert and oriented x 1, range of motion within the baseline.

On 1/12/25 at 10:50 AM and 1:03 PM, interviewed V10 (Agency Registered Nurse) and stated that V10 is the nurse in charge for R1 and R2. V10 stated that R1 needs one person assistance when walking with the use of a rolling walker. V10 stated R1 is confused. V10 stated that R2 is also ambulatory using a rolling walker. V10 stated R2 needs one staff assistance with walking because R2 gets confused and forgetful and is high fall risk.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/12/25 at 11:02 AM, interviewed V2 (Director of Nursing) and stated that V2 witnessed the incident that happened with R1 and R2 on 9/13/24 at around 7:10 PM. V2 stated, I went to the floor to do rounds. When I came out the elevator, I turned left to go down the hall and saw [R1] and [R2] walking together. There were no staff walking with them. [R1 and R2] were not using their walkers. [R1] was holding [R2] and walking together. Back there on the third-floor unit there is a cove. There is a countertop on the hallway like an island. I saw [R2] began to fall and [R1] was holding on to [R2] they were walking face to face holding each other's both hands. [R2] was walking backwards and then [R2] lost [R2's] balance and fell backwards. [R2] kind of slid down the wall. [R2's] back was leaning on the wall. [R1] was still holding [R2's] hands and went forward hitting [R1's] face on the countertop. [R1] had a nasal bone fracture. [R1] went to [Acute] hospital. V2 stated that fall assessment is completed upon admission, post fall, quarterly, and re-admission. V2 stated that the fall assessment's purpose is to assess the resident they are high fall risk. V2 stated that the care plan would address fall interventions to prevent from residents' from falling. V2 stated fall interventions include the resident's needs, based on the fall assessment, and is updated based on the root cause analysis post fall. V2 stated that R1 ambulates by herself with a walker and is quite independent. V2 stated that R2 has a walker needs assistance with walking. V2 stated that R2 is very forgetful and needs multiple re-direction. V2 stated that R2 needs staff assistance with walking, toileting, and transfer. A follow up interview conducted with V2 on 1/12/25 at 3:47 PM and stated that there were no other staff witnesses for R1 and R2's incident. On 1/12/25 at 1:10 PM, a phone interview conducted with V12 (Licensed Practical Nurse) and stated that R1 has dementia, walks with a walker, and wanders around. V12 stated that when R1 she walks somebody has to be with [R1]. V17 stated, We have to keep an eye on [R1] and supervise [R1]. [R1] is high risk for fall. [R1] forgetful. [R1] uses a rolling walker, and [R1] needs to use that all the time. [R2] also walks with walker and is more disoriented than R1. [R2] only speaks Spanish a little bit English. [R2] needs supervision at all times when walking. [R2] is a high fall risk. [R2] also needs rolling walker at all times. Surveyor asked V12 regarding the incident that happened on 9/13/24 with R1 and R2. V12 stated, I can't recall the exact time. I was passing medication at that time. It was evening meds. I can't recall the exact time. [V2] brought to my attention that [V2] witnessed [R1] and [R2] were walking holding hands. They were not using the walkers. [R1] lost balance and bumped [R1's] nose on the countertop by the front of [R1's] room. I did a full assessment for both. I took care of [R1]. [R1] was not complaining of pain after the incident but [R1] was holding [R1's] nose. We saw discoloration on [R1's] nose, no bleeding, just a superficial cut on the bridge of [R1's] nose. At that time [R1] did not complain of pain. [R1's] vitals were stable. We called 911 and the doctor. V12 stated that R1 came back to the facility the same night with nasal fracture as R1's diagnosis. On 1/12/25 at 4:38 PM, a follow-up phone interview was conducted with V12. V12 stated that V12 cannot recall what time the last time [V12] saw R1 and R2 before the incident. V12 stated that [V12] can only remember that R1 was in the dining room and R2 was in R2's room the last time V12 saw R1 and R2. On 1/12/25 at 1:33 PM, interviewed V13 (Restorative Licensed Practical Nurse) and stated that the Section GG of the MDS shows the resident's functional assessment, including their mobility assessment. V12 stated that if the resident 's MDS is coded supervision or touching assistance for example if a resident is walking with a walker, the staff should be cuing, reminding, or guiding the resident during walking activity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/12/25 at 3:37 PM, I attempted to conduct a phone interview with V14 (Former Certified Nursing Assistant/CNA). Surveyor asked about the incident with R1 and R2 on 9/13/24. V14 stated that V14 is very sick and can't talk. V14 refused to be interviewed. On 1/13/25 at 10:24 AM, a phone Interview conducted with V18 (Nurse Practitioner) and stated that V18 knows about the incident that happened on 9/13/24 between R1 and R2. V18 stated that R1 sustained the nasal fracture from the incident and was sent to the hospital. V18 stated that based on R1 and R2's cognitive and mobility statuses, R1 and R2 need staff supervision when walking and needs frequent monitoring. Surveyor asked V18 that if staff supervised and monitored R1 and R2 with walking would the incident had been prevented. V18 stated, I'm sure the incident would not happen. On 1/13/25 at 10:33 AM, a phone interview conducted with V2 and stated that for confused residents who are high risk for falls, fall interventions that the staff should be doing are frequent monitoring, re-direction, and to make sure residents are engage with activities. V2 stated that frequent rounding means the staff (Nurses and CNAs) are checking on residents every half hour. The facility's Fall Occurrence policy dated 7/26/24 documents in part: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. The facility's General Care policy dated 7/30/24 documents in part: It is the facility's policy to provide care for every resident to meet their needs. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include, but are not limited to ADL, wound care, medical needs, etc. Psychosocial needs would include but are not limited to areas of mental and psychosocial well-being. The facility will assist the resident to meet these needs, unless it shows that the resident's needs cannot be met in the facility.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to ensure medications were administered as scheduled per physician orders to 3 (R3, R4, R5) out of 3 residents reviewed for medication administration. Findings Include: On 1/12/25 at 9:13 AM, I interviewed R3. R3 stated that yesterday (1/11/25), R3 received [R3's] 9:00 AM medications closed to lunch time. R3 stated they were two hours late. On 1/12/25 at 10:26 AM, the Surveyor observed V8 (Agency Registered Nurse) enter R4's room and administer two insulin injections and medication pills to R1. The Surveyor asked what [V8] had just given to R4 and stated that those were R4's 9:00 AM medications. On 1/12/25 at 10:31 AM, R4 stated that sometimes on weekends, [R4] would get [R4's] medications late, sometimes one hour to two hours late. On 1/12/25 at 10:37 AM, R5 stated that [R5] does not pay attention with the time [R5] gets [R5's] medications and is not sure if [R5's] getting them on time or not. On 1/12/25 at 10:38 AM, V11 (Agency Registered Nurse) prepared R5's 9:00 AM medications. On 1/12/25 at 10:41 AM, R5 took all R5's medications. V11 stated that [V11] documents in the resident's chart that medications were administered after and not before administering medications. V11 stated that [V11] signs off the EMAR (Electronic Medication Administration Record) what were administered. V11 stated, We have to document after just in case resident's refuse their meds. R3's face sheet listed diagnoses, including Orthostatic Hypotension and Syncope and Collapse. Minimum Data Set (MDS) dated [DATE] shows R3 is cognitively intact with BIMS (Brief Interview for Mental Status) of 15. R3's Medication Admin Audit Report printed on 1/12/25 at 10:20 AM shows that on 1/11/25, R3 had ordered and scheduled medication of Midodrine 5 mg by mouth three times a day to be administered at 9:00 AM but was documented administered at 11:48 AM, more than two hours past the scheduled administration time. A review of R3's electronic health records (EHR) does not show any documentation that the physician was notified of the late medication administration for R3. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's face sheet listed diagnoses not limited to unspecified atrial fibrillation, chronic kidney disease, type 2 diabetes mellitus with diabetic polyneuropathy, essential hypertension, and cerebrovascular disease. MDS dated [DATE] shows R4 is cognitively intact with BIMS of 14. R4's Medication Admin Audit Report printed on 1/12/25 at 11:45 AM shows that on 1/12/25, R4 had ordered and scheduled medications of Insulin Aspart injection 22 units plus insulin sliding scale to be administered at 8:00 AM, but were documented administered at 10:27 AM and 10:28 AM, more than two hours past the scheduled administration times. R4 also had ordered and scheduled medications of Metformin 850 mg two times a day by mouth, Carvedilol 6.25 mg every 12 hours by mouth, Basaglar insulin injection 50 units two times a day, Apixaban 5 mg by mouth two times a day, Baclofen 10 mg by mouth three times a day, and Vascepa 1 gm by mouth two times a day to be administered at 9:00 AM, but were documented administered more than one hour past the administration scheduled time. A review of R4's electronic health records (EHR) does not show any documentation that the physician was notified of the late medication administration for R4. R5's face sheet has listed diagnoses but not limited to Multiple Sclerosis, Anemia, and Hyperlipidemia. R5's MDS dated [DATE] shows R5 has moderately impaired cognition with BIMS of 08. R5's Medication Admin Audit Report printed on 1/12/25 at 11:47 AM shows that on 1/12/25, R5 had ordered and scheduled medication of Ferrous Sulfate 325 mg by mouth two times a day and Methylphenidate 5 mg by mouth two times a day to be administered at 9:00 AM but were documented administered at 10:33 AM and 10:36 AM, more than one hour past the scheduled administration time. A review of R5's electronic health records (EHR) does not show any documentation that the physician was notified of the late medication administration for R5. On 1/12/25 at 11:02 AM, I interviewed V2 (Director of Nursing) and stated that medication administration is done one hour before and one after the scheduled administration times. V2 stated that nurses should follow the phsyician orders when administering medications. V2 stated that if the nurses give the medications late, they must call the doctor. V2 stated that after a resident takes their medications, the Nurses are documenting the time they administered the medications in the EMAR. V2 stated that they have to document what are given, what's missed and if it's late to call the doctor if it's a significant medication such intravenous medications, antibiotic, blood pressure medications, anticoagulant, insulins and antidiabetics. The facility's Physician Orders policy dated 8/16/24 documents in part: It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician orders. The facility shall ensure to follow physician orders as it written in the POS. Medication orders entered in the POS (Physician Order Sheet) shall be reflected accurately in the MAR (Medication Administration Record).