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	Statement of Licens 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)5)6) 300.1220b)3)	ure Violations:	12			3
	Section 300.610 Re	esident Care Policies			35	
3	procedures governir facility. The written be formulated by a F Committee consistin administrator, the admedical advisory con	hall have written policies and all services provided by the policies and procedures shall Resident Care Policy g of at least the lvisory physician or the mmittee, and representatives services in the facility. The	e de la			0
1	policies shall comply The written policies s the facility and shall l	with the Act and this Part. Shall be followed in operating be reviewed at least annually ocumented by written, signed	ma v			
	Section 300.1010 M	edical Care Policies		#		31
	physician of any acci change in a resident nealth, safety or welf out not limited to, the	nall notify the resident's dent, injury, or significant s condition that threatens the are of a resident, including, presence of incipient or lcers or a weight loss or gain		Attachment A Statement of Licensure Violations		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED IL6013098 B. WING 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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PRINTED: 04/04/2023

FORM APPROVED Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED IL6013098 B. WING 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 2 S9999 Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the nursing services of the facility, including:

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Developing an up-to-date resident care

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C IL6013098 B. WING 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months: These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to identify, assess, monitor and treat a pressure ulcer. The facility also failed to implement interventions to provide pressure relief modalities and prevent developing facility acquired pressure ulcer. This failure resulted in R1 developing a facility-acquired stage 3 pressure ulcer to the right buttock and was left untreated for unknown prolonged time. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 4. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on September 6. 2018. R1's most recent hospitalization was on January 12, 2023, for evaluation of low blood pressure. R1 was back to the facility on 1/13/2023. R1, a 77-year-old, with multiple

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diagnoses including diabetes mellitus type 2,

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C **B. WING** IL6013098 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 hemiparesis and hemiplegia due to cerebral infarction, major depressive disorder, dementia. peripheral vascular disease and amputee or absence of tight great toe and partial of the right foot. The MDS (Minimum Data Set) dated 1/13/2023 shows R1 has moderately impaired cognition (BIMS-Brief Interview Mental Status- a score of 11/15). R1 requires extensive assistance with two plus person physical assist for transfer. supervision with one-person physical assist for bed mobility, dressing, hygiene. R1 required physical help with bathing. R1 is usually incontinent of bladder function and has colostomy bag for bowel elimination. R1 shows a score of 0 /none for pressure ulcer. The MDS under behavior shows a score of 0 for no behavior and 0 for rejection of care. The MDS dated 12/16/2022 shows that R1 required limited assistance with 1-person physical assist for transfer, toileting, hygiene, and bathing. There were 0 scores for behaviors and rejection of care. R1 has limited range of motion bilateral lower extremities. There was 0 score for no pressure The skin evaluation dated 1/10/2023 shows R1 as high risk (Braden Score of 20) for developing pressure ulcer. Further review of skin evaluation shows that R1 has current skin alteration to the left lower leg, and right dorsal foot due to history of arterial insufficiency. This evaluation shows that R1 had no pressure ulcer.

The quarterly dietician evaluation dated

prevent skin breakdown.

12/12/2022 shows that R1's skin was intact. The evaluation also shows that the goal for R1 was to

	ENT OF DEFICIENCIES		iii Annalai	The second section is a second second	Let I SINIV	AFFROVEL	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	The care plan dated alteration that addre due to the arterial ci specific preventative	I 1/13/2023 shows skin assed R1's foot open wound reulation. There was no emeasure in place to prevent facility acquired pressure		77 1990 II IV			
el	The facility's shower scheduled to showe and Saturdays-7:00 Sheet/Skin Audit For 2022, through Janua The shower sheets s	r schedule shows that R1 was r twice a week (Wednesdays A.M7:00 P.M.). The Shower rm of R1 dated December 15, ary 18, 2023, were reviewed. shows that R1 was given a 2 for a period of a month.	ž				
e 1948	from December 15, 2023, was reviewed Nursing Assistant/Ch said that she collects to residents and files	D P.M., R1's shower sheets 2022, through January 18, with V6 (CNA- Certified NA Preceptor/scheduler). V6 the shower sheets provided them in the shower book.					
# 5 (9)	V6 said that R1 was showers for one mor 15,2022 through Jan added that during sh- done by the CNA tha	only given 2 out of 10 onth period (December uary 18,2023). V6 also ower day, skin check was t provided the shower and	36	9 \$6 Tr	2	111 200	
¥0.	preferred V13 (CNA) V6 further stated that sheet/skin audit, and showers, R1 was only audit on 12/25/2022	ssigned to the resident. V6 can be difficult as he to provide shower to him. based on the shower electronic documentation for y provided shower and skin and 1/9/2023. V6 added that	**		e e	¥	
XX	In case he would pref V13. These shower s shows that R1 was no the left leg. There was such as pressure ulce	te measures provided to R1 fer other CNA in addition to heet dated 12/25/2022 oted with skin alteration to s no other skin alteration er. The shower sheet of shower/skin audit was done	la i		in the	ja j	

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6013098 B. WING 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 \$9999 and did not show any skin alteration. The progress notes dated 1/12/2023 at 4:45 P.M. shows that R1 was sent to the hospital for evaluation due to low blood pressure. The progress notes dated 1/13/2022 shows that R1 had returned to the facility at 12:30 A.M. The notes also show that R1's "skin intact." The notes did not reflect on the open wound to the dorsal portion of right food documented on 1/10.2023. There was no Skin Evaluation/Assessment upon R1's returned to the facility on 1/13/2023. On 1/18/2023 at 4:30 P.M., V2 (Director of Nursing) stated that facility's standard of practice was to perform thorough Skin Evaluation/Assessment when a resident has returned back to the facility either a hospital visit or readmission. On 1/18/2023 at 10:00 A.M., V14 (RN-Registered Nurse/Emergency Department at acute hospital) stated that she remembers R1 because R1 was very unkempt, with very dry discolored almost to blackish discoloration of the left lower leg, and an open wound of the right dorsal foot. V14 stated that R1's skin especially to the lower extremities were very dry that when R1's pants was removed, skin was peeled off with the pants with skin flakes all over. V14 added that R1 was at the ED on 1/12/-13/2023. V14 stated that R1 has a stage 2 or 3 pressure ulcer to the right lower buttock. V14 stated that there was blood oozing from R1's pressure ulcer and no dressing was noted. On 1/18/2023 at 3:00 P.M., V10 (Wound Care Nurse) stated that together with V8 (Wound Care

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6013098		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
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2 1/ ₂ 11	wounds that are eit	nanage skin alteration including ither pressure ulcers or arterial /10 stated that R1 currently has and only has the right dorsal			W	
. =	foot wound which v	was arterial in nature.	Ú.	E 24		T.
	Practical Nurse from	0:30 A.M., V11 (LPN/License om agency staffing) who was 1/18/2023 stated that R1 has	40 114	E E 500	:= ::	(0)
	no pressure ulcer. \	V11 stated that R1 left the 023 around 9:30 A.M. for	*	9 9 9 5	8 V	10 102
žo.	Nurse Assistant from	0:40 A.M., V5 (CNA/Certified om staffing agency) stated that e ulcer and does his own ADL Living) by himself.			<	a a
n+ ⁸ a	Nurse from staffing taken care of R1 at sending him out to t	58 P.M., V15 (Registered gagency) stated that he had t least three times prior to the hospital on 1/12/2023 at	5,5	2 2 2 9	e	
55 66	and oriented 2-4 sp forgetfulness, was a but needs assistand meal set up. V15 ad	/15 described R1 being alert pheres with bouts of able to propel own wheelchair ce from staff for dressing, and dded that she did not check or presence of pressure	. Ž	- A - 13	69 18 *** *********************************	
	V	45 P.M., R1 was observed	£	±	8.5	
i.	when he returned to treatment. R1 was s was alert and orient to the left side of his to the left side. R1 s	o the facility from his dialysis sitting in his wheelchair. R1 ted times 3. R1 has weakness is body and was noted leaning stated because of his stroke it move around. With R1's	=	ik.	> %	
	permission, R1 allow taken to his room.	wed for skin check and was	-	68	3	

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6013098 B. WING 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 8 S9999 Multiple staff including V2, V4 and V5 (CNAs), V9 (Wound Care Technician), V8 (Wound Care Nurse) were observed trying to encourage R1 to transfer self from wheelchair to bed. R1 was observed barely able to move his feet (right foot partially amputated) for transfer. The staff present encouraged him to scoot to bed and pull himself out from the wheelchair. However, R1 was not able too. The staff attempted to assist him and transfer R1 manually, however R1 was to stand up for short period. During this time, R1 agreed to have his sacral area observed. R1 was not wearing an incontinence pad, and fresh blood was oozing from the pressure ulcer of the right lower buttock. The blood just oozed from the right buttock down to the floor. R1 could not tolerate standing so the staff placed his pants back on and returned R1 to his wheelchair. R1's lower body, including hip and buttocks area was so stiff so the staff was unable to maneuver R1. R1 was then transferred to bed with the use of the mechanical lift. V8 and V9 assessed the pressure ulcer that was oozing. V8 said "Oh my I am so surprised with this pressure ulcer, no one had informed us about this. This is a stage 3 pressure ulcer of the right lower buttock. This pressure ulcer did not just happen to stage 3, it would have started at stage 1 and progressed to stage 3 which was the stage now. Nobody told us, the direct staff should had let me and (V10) know, if they were checking his skin, this pressure ulcer would have not missed and had progressed this far. We could have mornitored and provided treatment before it got this far. Not sure how long he has this pressure ulcer, but have we known, we would have provided wound treatment." V2 was present during this time and was also surprised with the stage 3 pressure ulcer acquired by R1. They

S9999 Continued From page concur that R1's curre pressure relieving dev was also just a vinyl predistribution modality sleep in his lounge rechair was made of vin relieving device/cushir R1's wheelchair pad a seat was with dried ble R1 stated "I have bed because I am sitting in not comfortable. I kno	### ### ### ### ### ### ### ### ### ##	B. WING DRESS, CITY, S' T BUTTERFIE ST, IL 60126 PREFIX TAG S9999		CTION DULD BE	
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sleep in his lounge rechair was made of vin relieving device/cushi R1's wheelchair pad a seat was with dried bl R1 stated "I have bed because I am sitting in not comfortable. I kno	y. V4 stated that R1 always			* 3	s n
R1 stated "I have bed because I am sitting in not comfortable. I kno	eclining chair. The reclining nyl and has no pressure ion. It was also noted that	9 (K.		e N	
because I am sitting in not comfortable. I kno	lood.	X			
DUILOUNG DOCUME I WE	n my wheelchair, and it is bw I have bedsores on my as told when I went to the				35 14
back here, no one gave	12, a week ago. I came ve me treatment, cream and ores. I always sleep in my se my back hurts when I	>			<u> </u>
sleep in my bed. The uncomfortable and did back injury from long	mattress was just d not help and I have also time ago." Prior to R1 being noted that the bed mattress		A 800-		20
was slightly sunken at mattress. This was po and one of them said	t the middle part of the pinted to the staff present "even the bed frame is not			i ge	
functioning, it does no	se) measured R1's right	8 8		Ē.	
lower wound and class ulcer, with measureme 4.5 cm in width, 0.20 c	sified it a stage 3 pressure ent of length as 11.5 cm x cm in depth. V8 described	114	# # # # # # # # # # # # # # # # # # #		
After V8 provide the tr	er with 5 % slough tissues. reatment to R1's pressure lock, V4 and V5 removed of him. R1's left lower)(a -)(a	ų i
extremities was severe blackish/leathery appe multiple spots of heavy	ely discolored with		ж ^д — в		

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6013098 01/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 WEST BUTTERFIELD ROAD BELLA TERRA ELMHURST** ELMHURST, IL 60126 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY)** S9999 Continued From page 10 S9999 definitely use a treatment lotion and hygiene." The facility's policy for "Wound Care" with revision date of 8/12/2021 and a reviewed date of 8/2022 shows that the purpose of the wound policy was to prevent development of pressure ulcer and purpose of treatment to promote pressure ulcer healing. "1. PROCEDURE: 1. Timely identification of resident assessed to be at risk for skin breakdown. a) The Braden Scale must be completed by license nurse on admission /readmission. c) Each risk factor and potential causes should be identified and reviewed individually and addressed to resident care plan. d) Facility should decide a plan of care and implement intervention. 3. Prevention of skin breakdown a) Daily regular hygiene c) inspection of the skin every shift with care for signs of breakdown f) Moisturize skin with lotion to hydrate skin soft and pliable h) Administer scheduled shower /bath and completion of Shower & Skin Audit Form and document findings. 4. Activity, Mobility and Positioning b) Establish an individualized turning and repositioning of resident is with impaired functioning. c) While in bed or wheelchair. resident should be turned and repositioned at least every 2 hours d) While in sitting position. resident should repositioned every 2 hours e) While in sitting position, if resident is capable of repositioning self, resident should be encourage to shift weight regularly to help relieve pressure on the sacral/ischial and or pressure point areas." The facility policy for "Shower & Hygiene" with revised date of 7/28/2022 shows "ensure that residents shower/hygiene care is provided by the nursing staff to promote cleanliness, provide

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comfort to the resident and observe condition of

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Illinois Department of Public Health

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