STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000889	A. BUILDING: _____ B. WING _____	C 03/07/2024

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BELLA TERRA MORTON GROVE	8425 WAUKEGAN ROAD MORTON GROVE, IL 60053

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S 000	Initial Comments Complaint Investigations: 2491005/IL169517 2490703/IL169136	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) 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	S9999		

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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)

b) 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.

d) 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:

6) 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.

These requirments were not met as evidenced by:

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Based on observation, interviews and record reviews, the facility failed to follow a resident care plan related to use of helmet for one (R3) of five residents reviewed for falls and injuries. This failure resulted in R3 sustaining a right subdural hematoma after a fall incident.

Findings include:

R3 is a 73-year-old female, admitted in the facility on 02/16/23 with diagnoses of Traumatic Subdural Hemorrhage without Loss of Consciousness, Subsequent Encounter; Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Unspecified Fall Subsequent Encounter and Epidural Hemorrhage with Loss of Consciousness Status Unknown, Subsequent Encounter. According to MDS (Minimum Data Set) dated 11/10/23 under Section C, R3 has BIMS (Brief Interview of Mental Status) score of 3, which means severe cognitive impairment.

R3's Fall risk evaluation notes dated 07/05/23, 07/27/23 and 01/30/24 recorded a score of 17 - 18 which means high risk for falls.

According to incident report dated 01/30/24, at around 6:30 AM, V14 (Certified Nurse Assistant, CNA) came into R3's room with all the materials needed for her (R3) to be changed and observed her (R3) on the floor next to her bed lying on her back. V14 immediately called V13 (Licensed Practical Nurse, LPN) and responded immediately. R3 verbalized "I don't know how it happened. I didn't hit the back of my head only my forehead." She (R3) complained of pain on forehead with a 3.0 cm (centimeters) laceration with bump, was given Tylenol for pain. Moderate

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bleeding was noted on the forehead. Pressure dressing and ice pack were administered to control the bleeding and was sent to the emergency room for further evaluation and management.

On 03/05/24 at 3:35 PM, V14 was interviewed regarding R3's fall on 01/30/24. V14 replied, "Around 5:45 AM to 6 AM, I went to her (R3's) room to change her (R3). She (R3) was still lying in bed. I told her (R3) that it is time to get changed. I went to grab some supplies in the cart. The cart was in front of her (R3's) room. While I was walking to grab the supplies, I heard her (R3) falling on the floor. I immediately came to her (R3) and saw her (R3) on the floor. It happened so fast. When I saw her (R3) on the floor, I noticed a laceration on her (R3's) forehead. She (R3) was not wearing the helmet. I put a pillow on her (R3's) head and left to go get V13. He (V13) came and did an assessment."

V13 was also interviewed regarding R3. V13 stated, "On 01/30/24, she (R3) had a fall. It happened early morning. V14 was to change R3. She (R3) was still in bed. She (V14) went out of the room and when she (V14) came back, she (R3) was already on the floor. She (V14) called me and I came into the room. She (R3) was on the floor. Her (R3's) forehead was bleeding. I put pressure on the forehead to stop the bleeding. When the bleeding stopped, I put a band aid, I applied cold pack. I asked if she (R3) has any pain, she (R3) said yes and I gave Tylenol. She (R3) was not wearing the helmet. I called paramedics as ordered and she (R3) was sent out."

R3's Hospital Records dated 01/30/24 recorded: CT (Computerized Tomography) Head without

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S9999	Continued From page 4 contrast final result - Right Convexity Acute Subdural Hematoma measuring up to 6 mm (millimeters) in thickness. On 03/04/24 at 12:00 PM, R3 was observed in the small dining room attending activities, in her wheelchair. R3 was alert, and able to respond yes when called by name and stated she was doing fine. She was observed wearing a soft helmet. She (R3) is able to verbalize needs and wants. Per V11 (CNA), R3 always wear the helmet even when in bed and sleeping. R3 is also able to tell staff if she wanted to go to the bathroom. R3 was asked regarding fall incident on 01/30/24, stated she don't remember anything about the fall and refused to answer further questions. On 03/05/24 at 10:54 AM, she (R3) was again observed in the small dining room attending activities, sitting in her wheelchair with her soft helmet on. She (R3) stated she wants to go to the bathroom. V11 provided assistance. On 03/05/24 at 4:23 PM, V12 (Fall Coordinator) was asked regarding R3. V12 verbalized, " She (R3) is alert, has impulsive behavior and has history of falls prior to coming to facility. That is why she (R3) wears the helmet 24 hours a day, even while sleeping. She (R3) has a behavior of removing the helmet. We have to always redirect her (R3) not to remove it. Staff has to make sure that the helmet is on. She (R3) has to be educated and reminded that she (R3) needs the helmet on at all times. On 01/30/24, she (R3) had a fall, early in the morning. I talked to V14, she (V14) said that she (V14) was doing rounds room to room and looked at R3. She (R3) was awake, and bed was at the lowest position, she (R3) was not in any distress. Her (R3) helmet was not on and was removed. Since she (R3) was in bed, she (V14) went outside to grab the supplies	S9999		

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S9999	Continued From page 5 from the cart. The cart was outside the hallway by the door. When she (V14) went to grab the supplies, she (V14) turned and saw her (R3) on the floor. The cause of her (R3's) fall was she (R3) has this impulsive behavior. All staff were aware of her (R3) impulsiveness. Staff to make sure helmet is on at all times. On 03/06/24 at 3:08 PM, V10 (LPN) and V11 stated during interviews that R3 is alert, oriented to self and place but confused. V10 stated, "She (R3) forgets things. She (R3) has a behavior of standing and walking to the bathroom without assistance. When she (R3) is in bed, she (R3) will yell for help, won't use the call light. Staff has to go there right away. If not, she (R3) is going to go by herself, right away. She (R3) is wearing the soft helmet. She (R3) came with the helmet, because she (R3) has previous history of head injuries. The helmet protects the head." V11 also added, "She (R3) wears the helmet during my shift." Both also verbalized, "If it happened that (R3) was not wearing the helmet, (R3) will look for it and ask for it. Even when (R3) sleeps, (R3) still must wear the helmet. During our shift, we have never seen (R3) removing the helmet." R3's care plans documented the following: (Date initiated 03/01/23) General behavior symptoms: Frequently removes helmet Interventions: Conduct a review of the behavioral symptoms to determine what strengths or abilities and needs are communicated via the behavior (example "verbal behavior" or "verbal aggression" often communicates a need to feel in control and assertive) Give psychoactive medication as ordered. Record behavioral symptoms (example, verbal/physical aggression, inappropriate behavior) and side	S9999		

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S9999	Continued From page 6 effects (example, tardive dyskinesia, anticholinergic effects) Refer R3 to the consulting psychiatrist for a psychiatric evaluation, as warranted. (Date initiated 02/21/23) R3 admitted with soft helmet, on at all times for medical necessity. R3 can take it off upon command and put it back on Interventions: Staff to monitor any negative or adverse effects noted, including skin breakdown, signs and symptoms of delirium, fall/accidents/injuries, agitation, weakness. (Date initiated 06/13/23) At risk for falls related to cognitive impairment, decline in functional status, depression, impaired balance during transitions, impulsivity or poor safety awareness and recent fall Interventions: I have periods of forgetfulness, I would like staff to frequently reorient me to my surroundings. R3's hospital records dated 01/31/24 under History and Physical Note also documented that she has a history of left-sided stroke with craniotomy and subsequent cranioplasty back in 2010. On 03/06/24 at 3:26 PM, V15 (Nurse Practitioner) was asked regarding R3 and use of helmet during fall incidents. V15 replied, "(R3) had a fall and had history of craniotomy, has neurocognitive issue. The soft helmet protects the head for injuries during falls. (R3) does not have normal protection of the head due to craniotomy. During fall incidents, the soft helmet can possibly protect (R3) from developing the subdural hematoma. The soft helmet reduces the risk of head injuries to happen during fall. Staff has to do a lot of	S9999		

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redirections since (R3) has a behavior of removing it from time to time. (R3) must be redirected and monitored that she wears the helmet at all times."

V2 (Director of Nursing) also verbalized during interview on 03/06/24 at 3:40 PM, "(R3) has Dementia, and has behavior of impulsiveness. (R3) must wear the soft helmet at all times, even when sleeping. (R3) has a behavior of removing her helmet, so staff has to do redirection and monitor if she wears the helmet at all times. Back in 2010, she had a history of traumatic brain injury. Admitted back to us in 2022 and had the helmet on. We continued the helmet. Wearing the helmet is part of the fall intervention due to history of brain injury which was caused by a previous fall. Her fall incident last 01/30/24, (R3) sustained laceration on the forehead and was diagnosed with right sided subdural hematoma. The CNA (V14) mentioned that she saw her (R3) that morning that (R3) was not wearing the helmet while in bed. She (V14) should redirect the resident to put the helmet back on at that time before she gets the supplies. Staff has to follow what is being care planned on R3. If the care plan states (R3) should be wearing the helmet, (R3) should be wearing the helmet at all times. If (R3) removes the helmet, staff has to redirect and asked her (R3) to put the helmet back on. Staff has to monitor her (R3) for any untoward behaviors."

Facility's policy titled "Fall Occurrence" dated 07/17/23 stated in part but not limited to the following:
Policy Statement:
It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions

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S9999	Continued From page 8 are reevaluated and revised as necessary. (A)	S9999		