

Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0057034</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                            |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>08/04/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>BELLA TERRA BLOOMINGDALE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>165 SOUTH BLOOMINGDALE ROAD , BLOOMINGDALE, Illinois,<br/>60108</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |  | ID<br>PREFIX<br>TAG                                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S0000                                                           | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |  | S0000                                                                                                           |                                                                                                                          |                                                 | 08/14/2025                 |
|                                                                 | Complaint Investigation 2576985/2575542,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | Final Observations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
| S9999                                                           | STATEMENT OF LICENSURE VIOLATIONS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                         |  | S9999                                                                                                           |                                                                                                                          |                                                 | 08/14/2025                 |
|                                                                 | 300.610a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | 300.1210b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | 300.1210d)6)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | Section 300.610 Resident Care Policies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | a) The facility shall have written policies and<br>procedures governing all services provided by the facility.<br>The written policies and procedures shall be formulated by<br>a Resident Care Policy Committee consisting of at least<br>the administrator, the advisory physician or the medical<br>advisory committee, and representatives of nursing and<br>other services in the facility. The policies shall comply with<br>the Act and<br>this Part. The written policies shall be followed in operating<br>the facility and shall be reviewed at least annually by this<br>committee, documented by written, signed and dated<br>minutes of the meeting. |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | Section 300.1210 General Requirements for Nursing and<br>Personal Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |
|                                                                 | b) The facility shall provide the necessary care and<br>services to attain or maintain the highest practicable<br>physical, mental, and psychological well-being of the<br>resident, in accordance with each resident's<br>comprehensive resident care plan. Adequate and properly<br>supervised nursing care and personal care shall be<br>provided to each resident to meet the total nursing and<br>personal care needs of the resident.                                                                                                                                                                                                                       |                                                                         |  |                                                                                                                 |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0057034</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>08/04/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>BELLA TERRA BLOOMINGDALE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>165 SOUTH BLOOMINGDALE ROAD , BLOOMINGDALE, Illinois,<br/>60108</b>          |  |                                                 |  |
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| S9999                                                           | <p>Continued from page 1</p> <p>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:</p> <p>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.</p> <p>THESE REQUIREMENTS WERE NOT MET EVIDENCED BY:</p> <p>Based on interview and record review, the facility failed to safely transfer a resident with a mechanical lift. This failure resulted in R1 sustaining a closed fracture of the distal end of his right femur and requiring surgery.</p> <p>This applies to 1 of 4 residents (R1) reviewed for transfers.</p> <p>The findings include:</p> <p>R1's EMR (Electronic Medical Record) showed R1 admitted to the facility on 11/16/2018 with multiple diagnoses, including hemiplegia and hemiparesis related to cerebral infarction affecting his left side, spinal stenosis, general weakness, decreased mobility, polyneuropathy, and contractures to his lower extremities. R1's care plan with a review date of 6/18/2025 said R1 had a self-care deficit with his activities of daily living and required physical assistance of two-staff members. R1's care plan said he was dependent on bed mobility and transfers and required the use of a mechanical lift.</p> <p>On 8/02/2025 at 10:20 AM, R1 was in bed. R1's legs were severely contracted. R1's left lower leg was hyperextended in a fixed flexed position towards his pelvic area, and the right lower leg was in a straight fixed position. R1's right lower leg had surgical scars. R1 was unable to move his lower body. R1's memory was impaired and was he unable to provide details regarding the right femur fracture that occurred on 5/27/2025.</p> <p>On 8/04/2025 at 8 AM, V20 and V21 (R1's Family Members) said they had concerns regarding R1's assisted mechanical lift transfer on 5/27/2025. They said R1 informed them he had acute pain in his right lower leg after he was transferred by V4 and V5 (Certified Nurse Assistants/CNAs). V21 said she accompanied R1 to his</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                           | <p>Continued from page 2</p> <p>medical urology appointment on 5/27/2025, and R1 did not have any injury or vocalized pain in his right lower leg. V21 said R1 had to be assisted back to his bed from his wheelchair after he returned to the facility. V20 said the facility called her later that evening, informing her R1 was having acute pain and swelling to his right lower leg and was going to have x-rays done at the facility. V20 said she was then informed R1 had a fracture to his right leg and had to be transferred to the hospital. V20 said she informed V1 (Administrator) about R1's transfer concern on 5/27/2025 because they were concerned about his safety.</p> <p>On 8/04/2025 at 2:50 PM, V5 (CNA) said V4 assisted her with R1's mechanical lift transfer when he returned from his appointment at approximately 1 PM. V5 said R1's legs were severely contracted. V5 said she maneuvered the lift machine while V4 placed his hands behind R1's back to direct him into the bed. V5 said no one was supporting or guiding R1's legs to safely position them onto the bed. V5 said R1 was complaining of pain, and she informed the nurse on duty.</p> <p>On 8/04/2025 at 12:30 PM, V4 (CNA) said he assisted V5 with R1's mechanical lift transfer after his appointment on 5/27/2025. V4 said he was behind R1 while V5 started to operate the machine. V4 said R1's legs went on the bed first and then his upper body. V4 said he was unable to visually see R1's legs during the transfer. V4 said R1 was severely contracted, and his legs were not supported during the transfer.</p> <p>On 8/04/2025 at 9 AM, V11 (CNA) said on 5/27/2025 at 3:30 PM during rounds R1 declined care, and at approximately 6 PM she attempted to provide care again. V11 said R1 reported "they hurt me" and was complaining of severe right leg pain. V11 said she then removed R1's sheet to assess, and his right leg was abnormally positioned and deformed. V11 said she informed the nurse on duty immediately.</p> <p>On 8/04/2025 at 12 PM, V23 (Restorative Nurse) said staff were expected to follow the facility's mechanical lift transfer policy to ensure the safety of residents during transfers. V23 said two staff members were required for mechanical lift transfers. V23 said one staff member was required to operate the machine while the second staff member safely guided the resident during the transfer. V23 said for residents with limited mobility in their legs, the second staff member had to safely hold their legs for support to prevent an injury during the transfer. V23 said staff were expected to report any injury or incident during transfers to ensure the safety of residents.</p> |                                                                         |  | S9999                                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                           | <p>Continued from page 3</p> <p>On 8/04/2025 at 4 PM, V22 (Physician) said she was notified of R1's abnormal right lower leg x-ray results on 5/28/2025. V22 said R1 had to be transferred to the hospital and had surgical nailing of his femur. V22 said R1 was severely contracted and required staff assistance with his care. V22 said she expected facility staff to transfer residents safely as per their policy to ensure resident safety.</p> <p>R1's hospital records dated 5/28/2025 said R1 started to complain of acute pain and swelling in his right leg after he was transferred with a mechanical lift when he returned from a medical appointment. The records said R1 had a closed fracture of the distal end of his right femur and required an orthopedic surgical procedure on 5/29/2025.</p> <p>R1's progress note dated 5/28/2025 at 3 AM said R1's STAT (immediate) x-ray results were pending and was still having "...right knee pain, swelling, and warmth also observed on right knee area. Immobilized right lower extremity as much as possible." R1's follow-up note at 6 AM said R1's x-ray "...revealed right distal femoral fracture" and R1 was transferred to the hospital for further management.</p> <p>R1's incident statement dated 5/29/2025 said R1 was reinterviewed regarding his statement of his injury being caused during his mechanical lift transfer on 5/27/2025 and said, "It hurts...[V4] was messing with my legs in the lift." The statement said R1 was unable to provide further details regarding his statement.</p> <p>The facility's policy titled Mechanical Lift Transfers dated 7/02/2025, said "11. Lift resident up from the chair using lift with 1 person operating the machine while the other staff removes the resident's wheelchair/recliner...Then 2nd staff will guide resident and sling as resident is transferred and lowered back to bed. 13. Check resident's comfort after the task is completed..."</p> <p>(A)</p> |                                                                         |  | S9999                                                                                                           |                                                                                                                          |                                                 |                            |