STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145198	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELLA TERRA MORTON GROVE	8425 WAUKEGAN ROAD MORTON GROVE, IL 60053

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview and record review, the facility failed to ensure that bed alarms were in place and/or in functional order for three residents (R2, R4, and R6) and failed to ensure that appropriate footwear was utilized for one resident (R7) reviewed for falls with major injuries in a sample of seven. Findings include: R2's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. Minimum Data Set ((MDS) dated [DATE] documents that R2 requires extensive assistance from one person to transfer between surfaces. R2's medical record documents that R2 has experienced two falls. One on 4/25/20, an unwitnessed fall that occurred when R2 attempted to walk to the bathroom independently. On 7/15/20 at 6:15am, R2 experienced another fall as she tried to walk to the bathroom independently. R2 was transferred to a local hospital and diagnosed with [REDACTED]. The Post Incident Investigation documented: Interventions to address incident - Sensory pad alarm to remind resident to call for help and alert staff when resident is attempting to get out of bed unassisted. The need for a bed alarm is also documented in R2's care plan. 8/26/20 at 12:30pm, R2 was sitting up on the side of her bed with a tray table in front of her. R2 shifted in bed to get closer to the edge of the bed stating that the bedside table was too far away to reach her lunch tray. As R2 moved in bed, it was noted that there was no bed alarm attached to any portion of the bed. There was no sensory pad noted on R2's mattress. R2 moved her bed linens and indicated that this bed did not have an alarm. R2 stated, What bed alarm? This bed doesn't have that. My old bed did. I moved rooms a couple days ago because the toilet was broken. According to R2's medical records, it had been two days since R2 was moved to her current room. R2's progress note dated 8/24/20 at 1:00pm documents that R2's Power of Attorney was notified of R2's temporary move to another room. 8/26/20 at 12:33pm, V5 (RN-Registered Nurse) stated, She has a bed alarm. Most definitely, she needs that. She had a fall two or three weeks ago. She just had her cast removed. She doesn't follow instructions. Always have to instruct her to use her call light but she doesn't. She's alert but stubborn. V5 went to R2's room and noted that there was no bed alarm/bed sensory pad attached to R2's new bed.V5 went to R2's old room and found the sensory pad and bed alarm monitor still in place on the old mattress in R2's previous room. V5 picked the pad and monitor up and stated, She should have this. I'll put it there right away. R4's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R4's MDS dated [DATE] documents that R4 requires extensive assistance from two+ persons physical assist to transfer between surfaces. R4's medical record documents that R4 has experienced five falls without injury - 9/8/19, 12/6/19, 12/12/19, 2/5/20 and 5/4/20. Four falls occurred while R4 was in wheelchair and one fall was from bed. R4's Fall Risk Evaluation dated 5/5/20 documented that R4 was a High Risk for fall. Documentation shows that on 6/6/20 at 10:00am, R4 was found on the floor in her room after falling from her wheelchair. R4 was transferred to a local hospital and diagnosed with [REDACTED]. R4's Fall care plan documents, in part: 7/17/2017 - Educate resident with safety awareness. Utilize call light when needing assistance. (R4) will use an electronic bed alarm to alert staff that the resident requires assistance. Please make sure that my call light is within reach. Keep the bed in the low position. 8/26/20 at 12:24pm, R4 was sitting up in bed eating lunch. The bed alarm pad was in place but was not connected to the sensor monitor which was hanging on the upper hand rail of the bed. R4's call light was on the floor and her bed was not in the lowest position. At 12:37pm, V4 (CNA-Certified Nurse Assistant) checked R4's bed alarm and found that it was disconnected with the cord wrapped around a metal bar on the underside of the bed frame. It took V4 two minutes to untangle the cord from the bed frame. At 12:39pm, V4 plugged the cable into the sensor monitor and flipped the switch to on. V4 was ready to exit R4's room when this surveyor prompted V4 to pick the call light up from the ground. V4 stated, I don't know why it was disconnected and twisted under the bed like that. I don't know how long it's been like that. V4 confirmed that R4 had not gotten out of bed on his shift. R6's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. According to R6's Post Incident Investigation form, R6 has poor safety awareness, history of behavioral issues and unsteady gait. MDS dated [DATE] documents that R6 requires extensive assistance from one person physical assist to transfer between surfaces. R6 was admitted on [DATE] and his medical record documents that he has experienced four falls without injury - 6/16/20, 7/22/20, 8/18/20 and 8/26/20. Three falls occurred while R6 was in bed and attempted to walk and one fall was from the wheelchair. With three of the four falls, the staff was alerted by chair/bed alarms. R6's Fall Risk Evaluation dated 6/16/20 documented that R6 was a High Risk for fall. It is documented that on 7/3/20 at 5:15pm, R6 was found on the floor in his room after falling from bed. R6 was transferred to a local hospital and diagnosed with [REDACTED]. 8/26/20 at 12:38pm, R6 was in bed, moving from left to right and yelling. Despite, R6 moving in bed, there was no bed alarm sounding. At 2:29pm, V8 (CNA) and this surveyor entered R6's room to check the bed alarm. It was noted that R6 was laying on a sensor bed pad but that it was not connected to a sensor monitor. V8 checked the bed frame and did not find a monitor. V8 pointed to a sensor monitor that was hanging on R6's wheelchair but confirmed that R6 had not gotten out of bed that day for his shift. V8 stated, I'm not sure what happened to the bed alarm. It should be connected. He has been in bed all day. I did not see if the bed alarm was connected today. Maybe a resident disconnected it and took the part that plugs in. The bed alarm is important because he could fall. If he has it and tries to get out of bed, we could hear it and help him. I'll go get the bed alarm now and put it on. At 2:34pm, V7 (LPN-Licensed Practical Nurse) confirmed that she was R6's nurse. V7 stated, (R6) was in bed all day today. We did not get him up because he didn't feel well. Also, he seemed to be down emotionally. He ate lunch in bed. I don't know why the bed alarm is not connected. It should be because he is a very high fall risk. He needs to have it. It's my job to make sure he has a bed alarm. R7's Admission Record documents, in part, the following medical Diagnoses: [REDACTED]. R7's MDS dated [DATE] documents that R7 requires extensive assistance from one person physical assist to transfer between surfaces. R7 was admitted on [DATE] and his medical record documents that he has experienced six falls without injury - 10/11/19, 11/26/19, 12/24/19, 1/21/20, 2/3/20 and 3/27/20. Five falls occurred because R7 lost his balance. Only one of the five fall reports documented that R7 was wearing non skid socks at the time of the fall. R7's Fall Risk Evaluation dated 7/1/20 documented that R7 was a High Risk for fall. It is documented that on 7/1/20 at 7:30pm, R7 was found on the dining room floor with a three centimeter wound to the back of his head. R7 was transferred to a local hospital and diagnosed with [REDACTED]. R7's Post Incident Investigation does not document that R7 was wearing non-skid socks at the time of the fall. R7's Fall care plan documents, in part: 2/19/20 - Ensure that (R7) is wearing appropriate footwear (slip on shoes, non-skid socks correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in wheelchair. 8/26/20 at 12:45pm, R7 was in a common dining room with black socks on. At 2:23pm, R7 was walking in the common hallway in front of the nurse's station. R7 lost footing and then lowered self to kneel on the ground. It was noted that R7 had black dress socks on and was not wearing non-skid socks or shoes as care planned. V10 (LPN), V17 (Nursing Supervisor), V18 (Electronic Medical Records Nurse) and V19 (Admissions Director) were all present when R7 lowered himself to the ground. R7 was not assessed by the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) staff to see if he had on the correct footwear or non-skid socks. At 2:27pm, V9 (CNA) stated, (R7) should have non-skid socks on. I put them on him. He must've take them off. He's a high risk for falls without the no skid socks. V9 indicated that she does not know who put the black socks on R7. At 2:29pm, V10 (LPN) stated, I think (V9) put non-skid socks on him. He takes them off all the time. The black ones he's wearing? The CNA must have put them on him. He can't put them on himself. R7's interdisciplinary progress notes were reviewed from 6/5/20 through 8/25/20 without any documentation that R7 removes his non-skid socks independently. There is one entry dated 8/26/20 at 3:15pm that documents that R7 removes his non-skid socks. This is after the facility was made aware of the concern by the surveyor. R7's MDS dated [DATE] documents that R7 requires extensive assistance from one person to functionally drerss himself. R7 does have a care plan that addresses donning/doffing upper and lower clothing but does not document non-skid socks as a concern. 8/31/20 at 11:50am, V2 (DON-Director of Nursing) stated, We don't have a policy for bed alarms and we do not need an order for [REDACTED]. It it's in the care plan then it should be in place at all times except when the resident is supervised. 8/26/20 at 4:05pm, V11 (Falls Coordinator) stated, Fall alarms are important to alert staff if someone has gotten out of chair or bed. If resident stands up and alarm goes off, may be able to stop a fall. Same as if a resident is in bed, if staff hears the alarm, they can respond to it. Mostly, I'm in charge for putting them in as an intervention. It's everyone's job to make sure the alarms are in working condition. So checking them every shift or even when they provide care for them. If residents don't have awareness or wanderers, then we do implement no skid socks. A facility policy dated 8/3/16 and titled, Fall Occurrence documents: Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. Procedure: 2. Those identified as high risk for falls will be provided interventions to prevent falls.