STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016935	A. BUILDING: _____ B. WING _____	C 05/23/2022

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BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Complaint Investigations: 2282565/IL145317-330.710, 330.780, 330.785, 330.4240 2283038/IL145944-330.710, 330.780, 330.785, 330.4240 Investigation of Facility Reported Incident of 03-23-2022/IL145648-330.710, 330.780 Investigation of Facility Reported Incident of 04-08-2022/IL145648-330.710, 330.780 Investigation of Facility Reported Incident of 04-12-2022/IL145648-330.710, 330.780	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4: 330.710a) 330.710b) 330.710c)3)A)F) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. b) . All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. These Regulations are not met as evidenced by: Based upon record review and interview the facility failed to develop a written policy/procedure for care plans, failed to assess fall risk and failed to revise care plans (post fall) to decrease risk for additional falls/injury for four of seven residents (R6, R7, R8, R9) reviewed for falls. These failures have the potential to affect 108 residents. Findings include: The 3/30/22 census includes 108 residents. The 4/8/22 incident report states R6 fell at the facility (in the common area) and sustained a forehead laceration & subdural hematoma. R6's April 2022 care plan excludes a cognitive	S9999		

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S9999	Continued From page 2 assessment, fall risk and/or fall prevention interventions. The 4/12/22 incident report states R7 fell at the facility (in her room) and sustained a lumbar fracture. R7's April 2022 care plan excludes fall risk and/or fall prevention interventions. The 4/14/22 incident report states R8 fell at the facility (in the dining room) and sustained a forehead laceration & hematoma. R8's May 2022 care plan excludes a cognitive assessment, fall risk and/or fall prevention interventions. The 4/5/22 incident report states R9 fell at the facility (in her room) and sustained a left hip fracture. R9's May 2022 care plan excludes a cognitive assessment, fall risk and/or fall prevention interventions. On 5/19/22 at approximately 11:00am, surveyor requested the care plan policy. At 11:50am, V21 (Regional Vice President of Memory Care) presented a "personal care" policy for hygiene (which was not requested) therefore surveyor requested the care plan policy again. At 1:30pm, surveyor inquired about the requested care plan policy (which was not received) V21 responded, "I'm still looking for that." On 5/19/22 at 2:44pm, surveyor inquired about resident care plans V21 stated "The care assessment is done upon 30 days of admission or change in condition. That information is put into the system in the care approaches. They'll (staff) actually designate on those forms (referring to the care assessment report) what is needed for the patient and those will populate there (referring to the care plan)." Surveyor inquired about fall risk and cognitive assessments	S9999		

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S9999	Continued From page 3 V21 responded "Those would be there (referring to the care plan) if they entered them." A care plan policy was not received during this survey. The general procedures policy (reviewed 05/2003) states even though (facility) employs a Registered Nurse and Licensed Practical Nurses and Licensed Vocational Nurses individual residents will not receive skilled nursing services. The services provided include medication management, wellness checks, interventions in emergency situations or services approved by the Department. Statement of Licensure Violations 2 of 4: 330.780a) 330.780b) 330.780c) Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	S9999		

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S9999	Continued From page 4 c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These Regulations are not met as evidenced by: Based upon record review and interview the facility failed to report accurate narrative summaries to IDPH (Illinois Department of Public Health) for (R1, R6) post fall/injuries and failed to notify IDPH of reportable incidents/accidents within regulatory requirements for one of seven residents (R1) reviewed for falls/injury. On 4/8/22 R6 sustained a fall resulting in forehead laceration and subdural hematoma. On 3/13/22 R1 sustained a fall resulting in forehead lump and left arm/shoulder lacerations. Findings include: R6's 4/8/22 initial incident report/follow-up narrative summary states staff observed resident attempt to reposition herself when she (R6) suddenly fell to the floor. The resident sustained a	S9999		

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S9999	Continued From page 5 laceration to the forehead and a subdural hematoma. IDPH was notified of R6's 4/8/22 incident/injuries on 4/9/22 however R6's 4/8/22 progress notes state "fall was unwitnessed" which is incongruent with the narrative summary. On 5/12/22 at 12:27pm, surveyor inquired about R6's 4/8/22 fall. V20 LPN (Licensed Practical Nurse) stated "I remember that her head had some bruising" and affirmed she was unsure how R6 fell. R1's 3/13/22 initial incident report/follow-up narrative summary states surveillance system notified staff the resident was on the floor. Resident was alert with a lump noted to the left side of her forehead and a skin tear to the left elbow. Resident transported to Hospital for evaluation, discharged the same day and returned to the community approximately 1:30pm. The resident received steri-strips to her shoulder/arm and forehead. Bruising was noted to her face. IDPH was notified of R1's 3/13/22 fall/injuries on 3/15/22 at 2:38pm [2 days after the incident]. In addition, R1's 3/13/22 progress notes state resident sustained a "skin laceration" on left arm and shoulder which is incongruent with the narrative summary. On 4/14/22 at 12:10pm, surveyor inquired about the regulatory requirements for reporting incidents/accidents V1 (Executive Director) stated "When there's an injury and a transfer out the requirement is 24 hours for the initial and seven days for the final to IDPH." Surveyor inquired about reporting R1's 3/13/22 fall/injury V1	S9999		

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S9999	Continued From page 6 responded V2 DON (Director of Nursing) "had come on board and was working with our new nursing crew, there were problems with who they (Nursing) were notifying. This was a process communication issue in terms of this not being done on time." On 5/19/22 at 3:43pm, surveyor inquired about the potential risk for harm if a resident falls V22 (Physician) stated "They could have broken bones or a head injury." The reportable incidents and accident policy (reviewed 07/2009) states the facility will notify the department of any serious incident or accident meaning any incident that causes physical harm or injury to a resident. Notification will be made by fax or phone call to the regional office within 24 hours of each reportable incident or accident that causes physical harm or injury to a resident. A narrative summary of each reportable incident or accident will be sent to the department within seven days of the occurrence. Findings 1 & 2 = B Violation Statement of Licensure Violations 3 of 4: 330.785a)2) 330.785b)1) 330.785c)1) Section 330.785 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 2) Physical abuse ? see 77 Ill. Adm. Code 300.330.	S9999		

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S9999	Continued From page 7 b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; These Regulations are not met as evidenced by: Based upon record review and interview the facility failed to implement the resident abuse policy, failed notify police of staff to resident abuse, and failed to ensure resident safety for one of three residents (R3) reviewed for abuse. Findings include: R3's 4/7/22 initial abuse incident report and follow-up narrative summary excludes police notification. On 4/14/22 at 12:28pm, surveyor inquired about R3's 4/7/22 incident V1 (Executive Director) stated (R3) had a behavioral episode with hitting, kicking, attempting to bite towards V9 LPN (Licensed Practical Nurse) and she (R3) threw apple juice in her (V9) face. The Nurse (V9) didn't want her (R3) to hurt the PALS (Personal Assistant Liaisons), so she (V9) was holding her (R3) hands. The PAL (V8) was concerned about how the Nurse (V9) handled the resident in the situation, so we suspended her (V9). She (V8)	S9999		

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S9999	Continued From page 8 said she (V9) grabbed her (R3) wrists aggressively and twisted it. R3 was yelling let me go (V9) was still holding onto her (R3) wrists. (V8) felt that when they were walking her (R3) it was forceful, in her view it was aggressive. Surveyor inquired if the police were notified of the abuse allegation V1 responded "She (R3) was calm after the incident, and we moved on with the night. It was not reported to the Police. I didn't report it to Police because there have been interventions to address behaviors, staff were not injured, the resident (R3) was not injured." Surveyor inquired if abuse is supposed to be reported to the Police V1 replied "It is." V1 affirmed that V9 was not suspended until several days after the incident occurred. R3's 4/14/22 progress note include "old bruise noted to right wrist" and "weird pain in her right knee" which are injuries consistent with the abuse allegation. The 07/2005 resident abuse policy states the facility shall immediately contact local law enforcement authorities in the following situations: physical abuse involving physical injury inflicted on a resident by a staff member. Statement of Licensure Violations 4 of 4: 330.4240a) 330.4240d) 330.4240e) Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or	S9999		

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S9999	Continued From page 9 neglect a resident. (Section 2-107 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations are not met as evidenced by: Based upon record review and interview the facility failed to conduct a timely and thorough abuse investigation, failed to report resident injury to IDPH (Illinois Department of Public Health) post staff to resident abuse, failed to terminate staff and failed to ensure resident safety for one of three residents (R3) reviewed for abuse. These failures have the potential to affect 108 residents. Findings include: The 3/30/22 census includes 108 residents. R3's 4/7/22 initial incident report states on April 14th, a caregiver asked to meet with the Memory Program Coordinator. Concerns were expressed about rough care provided by the nurse on duty during an incident that occurred on April 7th. The Memory Program Coordinator brought this to the	S9999		

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S9999	Continued From page 10 attention of the executive director and an investigation was initiated. IDPH was notified on 4/13/22 [six days after the incident]. On 4/14/22 at 12:28pm, surveyor inquired about R3's 4/7/22 incident V1 (Executive Director) stated the PAL V8 (Personal Assistant Liaison) approached the Memory Programs Coordinator (V7) after the shift change meeting yesterday afternoon about an incident that occurred on the 4/7/22. (R3) had a behavioral episode with hitting, kicking, attempting to bite towards V9 (Licensed Practical Nurse) and she (R3) threw apple juice in her (V9) face. The Nurse (V9) didn't want her (R3) to hurt the PALS, so she (V9) was holding her (R3) hands." Surveyor inquired when the incident was reported to IDPH V1 replied "Not last week, it was yesterday. The PAL (V8) was concerned about how the Nurse (V9) handled the resident in the situation, so we suspended her (V9). She (V8) stated she (V9) grabbed her (R3) wrists aggressively and twisted it. (R3) was yelling let me go. (V9) was still holding onto her (R3) wrists, (V8) felt that when they were walking her (R3) it was forceful, in her view it was aggressive." On 4/21/22 at 1:35pm, surveyor inquired if R3 feels safe in the facility R3 stated "I'm seriously thinking about walking right out of here. I don't like the way I'm being treated, and the way other people are being treated." R3 advised that she has right knee pain and asked surveyor to "check it." Surveyor and V11 (Licensed Practical Nurse) assessed R3 at this time a large (yellow) bruise was observed on the right wrist/forearm and a scab was observed on the right anterior/lateral calf. Surveyor inquired if R3's injuries were acquired during 4/7/22 incident R3 replied "It could be."	S9999		

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S9999	Continued From page 11 On 4/28/22 at 12:35pm, surveyor inquired about the 4/7/22 incident V8 (PAL) stated "We had an incident where (V9) grabbed (R3's) hand and wrist and she turned it. I tried to pull her (V9) away from (R3) and (V9) said no, no leave her (R3) alone. (V9) pushed her (R3) backwards onto a chair. (V9) told me (V8) to call V10 (Wellness Coordinator) to calm her down. I then called my supervisor (V7) she didn't answer so I called (V1)" and affirmed V1 was notified on 4/7/22. Surveyor inquired if R3 sustained any injuries V8 responded "I worked with (R3) a few days later and saw a bruise on her (R3) wrist going onto her arm. I told (V7) about the bruise" and affirmed she reported it immediately. R3's 4/14/22 progress notes state talked with resident this AM, she (R3) states she feels good except for "weird pain" in her right knee. Old bruise noted to right wrist unknown etiology. R3's follow-up narrative summary incident report submitted 4/19/22 to IDPH states no evidence of injury to the resident was found. The investigation concluded that no abuse of the resident occurred. On 4/21/22 at 2:50pm, surveyor inquired why R3's follow-up narrative states "No evidence of injury to the resident was found" when a bruise to R3's right wrist and knee pain were documented 4/14/22. V1 affirmed she was unaware. V14 (Regional Director of Resident Care Services) affirmed she was aware of R3's injuries and documented the 4/14/22) progress note. Surveyor inquired if V9 is still working at the facility, V1 stated "She is." Surveyor subsequently requested witness statements obtained during R3's abuse investigation.	S9999		

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S9999	Continued From page 12 On 4/28/22 at 1:55pm, V1 presented handwritten notes (on blank paper) and stated, "We don't have signed statements, but these are staff interview notes." V8's witness statement (dated 4/6/22) states (V9) grabbed (R3's) wrist very aggressively and twisted it. (R3) was yelling "let me go." She (R3) began to get more aggressive kicking and punching (V9) is still holding tightly on her wrist. (V9) pushed (R3) all the way to the purple chairs. (R3) was on the side of the chair and (V9) is still grabbing her (R3) wrist. (V9) said "Keep on fighting, I'm trained to do this. We need to stop getting psych people if we don't want to hire a psychiatrist. (V10) she (R3) better not do anything as I walk away or I'll have to do something I don't want to do." V23 (PAL) witness statement (4/13/22) affirms "nurse (V9) grabbed her (R3) hands and (V8) grabbed her arms. Nurse (V9) and (V8) pushed (R3) backwards to sit her down." V24 (PAL) witness statement (4/13/22) affirms "nurse restrained her (R3) got resident to chair. (V8) helped restrain. Heard Nurse say she is trained to restrain people. R3 had bruises on her wrist." R3's progress notes, witness statements and actual injuries were noted to be incongruent with the facility findings and consistent with abuse. The (07/2005) resident abuse policy states employees will be trained as part of orientation and in ongoing sessions regarding issues related to abuse prohibition practices such as: what constitutes abuse. Any alleged violations involving mistreatment, neglect or abuse must be reported to the employee's immediate supervisor. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing and a variance report completed with	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 investigation procedure followed. If an employee is found to be guilty of any form of abuse they will be terminated. Findings 3 & 4 = B Violation	S9999		