Illinois Department of Public Health

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 ______	06/16/2022

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

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S 000	Initial Comments Annual Licensure Complaint Investigation: 2284343/IL147600 330.910b) 330.1145a) 330.1145d)	S 000		
S9999	Final Observations Statement of Licensure Violation 1of 3: 330.910b) Section 330.910 Personnel b) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. These Regulations are not met as evidenced by: Based on observations, interviews and record review, the facility failed to staff the facility with nurses to ensure that residents were administered their scheduled medications on time as ordered which affected R6, R7, R9 and R14 and has the potential to affect the 33 residents residing on the 5th, 6th and 7th floors who receive their medications from nurses in the facility. Findings include: On 6/7/22 at 9:22 am, this surveyor was present	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 on the 3rd floor of the facility to observe a medication pass and inquired with V7 (Patient Assistant Liaison, PAL) about the nurse's whereabouts, and V7 stated that V7 will message the nurse to come to the 3rd floor. On 6/7/22 at 9:24 am, V14 (Agency Licensed Practical Nurse, LPN) came onto the 3rd floor from the elevator. V14 stated to this surveyor that V14 is assigned to half of the 3rd floor residents, and the other nurse for the 3rd floor residents is V9 (Corporate Nurse, LPN). This surveyor asked what is V14's assignment for the 3rd floor. V14 stated, "I (V14) don't know. I (V14) have to find out who I (V14) have. We (V9 and V14) are supposed to be working together." V14 then exited the 3rd floor. On 6/7/22 at 9:38 am, V14 returned to the 3rd floor with V15 (LPN). V14 informed this surveyor about V14's resident assignment for part of the 3rd floor residents. V15 stated to this surveyor that V15 is assigned to the 2nd floor but is coming to help V14 on the 3rd floor. When asked if V15 normally will come and help with medication pass on the 3rd floor, V15 stated, "No" and that V15 was given directive by the nursing supervisor (V9). V14 attempted to sign into the electronic medical record (EMR) for medications. As V15 is assisting V14 with signing into the EMR, V15 stated to V14, "Get into the computer like this is your main floor." V14 stated, "I (V14) thought 4th floor was." On 6/7/22, this surveyor observed V14 (Agency LPN) and V15 (LPN) passing medications for but not limited to R6, R7, and R9. The following errors due to late administration were observed during this medication pass observation:	S9999		

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S9999	Continued From page 2 1. On 6/7/22 at 9:51 am, V15 administering R6 Divalproex 125 milligrams (mg) by mouth. R6's June 2022 Physician's Orders Statement (POS) documents, in part, "Divalproex 125 mg 1 cap by mouth twice daily at 8:00 am and 4:00 pm." 2. On 6/7/22 at 10:09 am, V14 administered R7 Midodrine 5 mg by mouth. R7's June 2022 POS documents, in part, "Midodrine 5 mg 1 tab by mouth daily for low blood pressure at 9:00 am and 5:00 pm." 3. On 6/7/22 at 10:08 am, V14 placed R7's Lidocaine 5% topical patch to lower back. R7's June 2022 POS documents, in part, "Lidocaine Pad 5% Rt (right) hip. Apply one patch daily on 12 hours and off 12 hours for pain. On 9:00 am." 4. On 6/7/22 at 10:08 am, V14 administered R7 Sotalol HCl (Hydrochloride) 80 mg by mouth. R7's June 2022 POS documents, in part, "Sotalol HCl 80 mg 1 tab by mouth twice daily at 9:00 am and 5:00 pm." 5. On 6/7/22 at 10:40 am, V15 administered R9 Gabapentin 300 mg by mouth. R9's June 2022 POS documents, in part, "Gabapentin 300 mg 2 caps (600 mg) by mouth twice daily at 8:00 am and 4:00 pm." On 6/7/22 at 11:06 am, V15 (LPN) stated, "I (V15) pass meds during normal hours. I (V15) have a window of two hours." When asked if a medication is scheduled at 9:00 am, when would V15 need to administer the medication for the timing window. V15 stated, "Between 8:00 am and 10:00 am to be on time." On 6/8/22 at 3:31 pm, V20 (Director of Resident Care Services, Sister Facility) stated that	S9999		

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S9999	Continued From page 3 medications are set to be delivered at a specific time. V20 stated that nurses must administer medications one hour before and one hour after medications are scheduled. V20 stated that the purpose of administering medications at the time they are scheduled is to achieve the "best effect of the medication." V20 stated, "It's important that meds be given within the time frame." On 6/7/22 at 2:34 pm, V2 (Activity Programming Director) stated that V2 was the manager on duty (MOD) on 5/28/22 and was present in the facility at 9:00 am on 5/28/22. V2 stated that there were two nurses working on the day shift in the facility on 5/28/22. V2 stated that when V2 was doing rounds, residents that were primarily on the 5th, 6th, and 7th floors were coming up to V2 and asking V2 if they were going to be getting their medications? V2 stated that V2 notified V1 of this information and was instructed by V1 to ask the nurses (V17 LPN, V18 LPN) to pass the medications to the 5th, 6th, and 7th floor residents. V2 stated that while on the phone with V4 (Senior Vice President of Clinical Services), V2 asked V17 and V18, who were on the 2nd and 3rd floors of the facility, to pass medications to the 5th through 7th floor residents and that V17 and V18 stated that they were too busy to go pass medications to residents on these floors. V2 stated that when V9 (Corporate Nurse, LPN) and V23 (Agency LPN) arrived to the 5th floor where the medication cart is for residents on floors 5 to 7, V9 retrieved the medication cart keys from V18. V2 stated that V2 then phoned V1 and V4, and a decision was made to not do the morning medication pass for the missed medications for residents on floors 5-7 and to start the evening medication pass since it was about to be the evening medication time.	S9999		

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S9999	Continued From page 4 On 6/8/22 at 10:43 am, V9 (Corporate Nurse, LPN) stated that V9 was called by V1 who informed V9 that medications were not being administered to residents, and V9 offered to come into work on 5/28/22. V9 stated that when V9 arrived on the 5th floor at 2:00 pm on 5/28/22, V9 observed V17 and V18 on the 5th floor, and asked V18 if any medications were passed to the residents on the 5th through 7th floors? V9 stated that V18 said that there wasn't a nurse for these residents (on the 5th through 7th floors). V9 stated that V9 spoke with V4, and V9 and V23 (Agency LPN) then began getting ready to start the evening medication pass for residents on the 5th through 7th floors. On 6/9/22 at 12:07 pm, V18 (Licensed Practical Nurse, LPN) stated that on 5/28/22, V18 was scheduled to the 2nd floor residents, V17 was scheduled to the 3rd and 4th floor residents, and that the nurse (V22, Agency LPN) who was scheduled for the 5th through 7th floors did not arrive. V18 stated, "That with the lack of nursing staff on 5/28/22, it was impossible to provide all the medications on time." On 6/8/22 at 1:46 pm, V1 (Executive Director) stated the Director of Resident Care Services (DRCS), when we have one employed, who oversees the scheduling of the nurses in the facility. V1 stated that V1 is currently responsible for staffing the nurses in the facility since there is no DRCS for this facility. V1 stated that during the day shift (1st shift), V1 staffs 3 nurses for the residents on the floors 2-7. When this surveyor showed V1 the LPN staff schedule for 5/28/22, V1 confirmed that V9 worked 1.8 hours on 5/28/22 during the day shift, and V23 (Agency LPN) worked 2 hours on 5/28/22 during the day shift. V1 stated that V17, V18 and V22 (Agency	S9999		

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LPN) were scheduled for the day shift on 5/28/22 and that V22 did not show up to the facility to work. V1 stated that it was "late morning" when V18 sent V1 a text message notifying V1 of V22 "no show." V1 stated that no resident on the 5th, 6th and 7th floors received their medications in the morning on 5/28/22. V1 stated that when V1 spoke with V2 (MOD), V1 instructed V17 and V18, who were finished passing medications on their assigned floor, to go up to the 5th, 6th and 7th floors to pass medications. V1 stated that the medications for the 5th, 6th and 7th floor residents would be late; however, V17 and V18 did not pass these late medications. V1 stated, "Their duty is to pass meds. It was appalling. Unbelievable." V1 stated that when V9 and V23 were present and able to pass medications to the 5th, 6th and 7th floor residents, "(V4) made decision to forgo the AM (morning) meds for (5th, 6th and 7th floor) residents. We couldn't double up on AM and PM (evening) meds, so it was close to PM meds, so PM med pass was done (on 5/28/22)."

On 6/8/22 at 2:42 pm, V4 (Senior Vice President of Clinical Services) stated that V4 covers 33 communities in 8 states and is responsible for the nurses for the clinical care aspects. V4 stated that on 5/28/22, V22 (Agency LPN) was scheduled for the day shift along with V17 and V18; however, V22 went to the wrong facility (a no show to this facility). V4 stated that V4 was in communication with V2 (Activity Programs Director) who was the MOD for 5/28/22. V4 stated that V2 informed V4 that residents on the 5th, 6th and 7th floors were not receiving their medications. V4 stated that via V2's phone, V4 attempted to speak with V17 who refused to speak to V4, and V4 then spoke with V18 about the plan to medicate the 5th, 6th and 7th floor

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residents on 5/28/22. V4 stated that when medications were still not being passed to the 5th, 6th and 7th floor residents on 5/28/22, V4 spoke with V9 (Corporate Nurse, LPN) who was in the facility now, and tried to figure out how to get medications to the diabetic residents. V4 stated, "Meds were not given. That's unsafe."

Facility staffing schedule, dated 5/28/22, documents in part for shift 6:30 am to 3:00 pm the following staff and hours worked: V9 (Corporate Nurse, LPN) for 1.8 hours, V17 (LPN) for 8.0 hours, V18 (LPN) for 8.0 hours, and V23 (Agency LPN) for 2.0 hours.

On 6/16/22 at 10:28 am, R14 stated, "I (R14) go to the 5th floor and get my medications. There are times that I (R14) have to wait because there's no nurse."

R14's May 2022 MAR documents, in part, a symbol indicating "Missed Dose" on 5/28/22 for the following medications:

1. Exetimibe 10 mg 1 tab by mouth daily. Scheduled at 9:00 am.
2. Florastor 250 mg 1 tab by mouth daily. Scheduled at 9:00 am.
3. Hydrochlorothiazide 12.5 mg 1 cap by mouth daily. Scheduled at 9:00 am.
4. Losartan Pot (Potassium) 100 mg 1 tab by mouth daily. Scheduled at 9:00 am.
5. (Eye Vitamin) 1 cap by mouth twice daily. Scheduled at 9:00 am.
6. Vitamin B Complex 1 cap by mouth twice daily. Scheduled at 9:00 am.

Facility policy dated May 2003 and titled "Medication Management," documents, in part, "Purpose: To assure safe and accurate supervision, assistance and/or administration of

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S9999	Continued From page 7 medications by a licensed professional acting within the scope of said license. Policy: 1. All medications will be dispensed through a pharmacy, prescribing physician ... 6. Medications will be stored in a locked cabinet ... 15. (Facility) supports administration, supervision ... of medications ... Procedure: I. Administration: For residents who choose not to, or that self-administer their medications: A. A RN (Registered Nurse), or LVN (Licensed Vocational Nurse) will administer medications at (facility), and may not pre-pour medications ... D. All drugs and biologicals must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements." Facility document dated 5/28/22 and titled "Community Census Report," documents, in part, that 50 residents were residing the 5th, 6th and 7th floors. Facility document dated 6/16/22 and titled "Resident Self-Medication," documents, in part, that 17 residents on the 5th, 6th and 7th floors who do not require nurses to administer their medications. (A) Statement of Licensure Violation 2 of 3: 330.1145a) 330.1145d) Section 330.1145 Restraints a) The facility shall have written policies controlling the use of physical restraints including,	S9999		

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but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part.

d) Physical restraints shall not be used on a resident for the purposes of discipline or convenience.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to allow a resident's egress from of a resident room by barricading the outside of the room door with a chair which affected three residents (R5, R13, R14) in a sample of fifteen residents reviewed for physical restraints.

Findings include:

R5's Face Sheet, documents, in part, that R5's diagnoses include unspecified Dementia with behavioral disturbance, Parkinson's disease and history of falling. R5's COVID-19 antigen test results, dated 5/21/22, documents a positive test result.

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R13's Face Sheet, documents, in part, that R13's diagnoses include Dementia and Anxiety. R13's nurse's notes, dated 5/24/22, document, in part, that R13 was on isolation due to testing positive for COVID-19 and that R13 was exit seeking.

R14's Face Sheet documents, in part, that R14's diagnoses include Spinal Stenosis and Macular Degeneration. R14's COVID-19 antigen test results, dated 4/22/22, documents a positive test result.

On 6/9/22 at 12:07 pm, V18 (Licensed Practical Nurse, LPN) stated that the facility will hire an external company for Dementia residents who test positive with COVID-19, so they do not leave their isolation rooms. V18 stated that R5 has Dementia and would try to walk out of R5's room when R5 was on contact and droplet isolation after testing positive for COVID-19 in May 2022. V18 stated that the care giver would wedge a chair underneath R5's door handle outside of R5's room door which would prevent R5 from being able to open the door from inside R5's room. V18 stated that the caregivers would then sit in the wedged chair. V18 also stated that V18 observed a wedged chair outside of R13's door (who was on contact and droplet isolation for COVID-19) to prevent R13 from exiting R13's room in May 2022.

On 6/6/22 at 11:28 am, V13 (Agency Caregiver) stated that V13 works through an external agency and worked three 12 hour shifts during the eleven days while R5 was on isolation for testing positive for COVID-19. V13 stated, "I (V13) stayed outside controlling (R5's) door." V13 stated, "I (V13) came and would stay behind the door in the hallway since (R5) was trying to get out, and (R5)

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was not allowed out because of having COVID. They (facility staff) were putting the chair outside so they would know when (R5) would try to open it or would need help. (R5) could not open the door. (R5) is not strong enough. On my day of working (coming in at 7:00 am), they (facility staff) would already have the chair there. I (V13) would see it there. I (V13) sat in a chair outside R5's room. PALs (Personal Assistant Liaison, PAL) would move the chair to open the door to pass through. Nurses would give medication, would leave (R5's) room and put the chair back." V13 stated, "The chair stayed there in place. It prevented (R5) from coming out of (R5's) room."

On 6/7/22 at 10:56 am, V12 (PAL) was asked when R5 was recently on isolation for testing positive for COVID-19, was there a physical object outside R5's room door to prevent R5 from leaving R5's room, and V12 stated, "Yes, there was a chair to prevent (R5) from leaving. The chair was right in front of the door on the outside in the hallway." V12 pointed out to this surveyor two chairs that were positioned in the waiting area outside R5's room. V12 stated, "I would move the chair every time to go in and out of (R5's) room."

On 6/16/22 at 10:20 am, V26 (PAL) stated that R13 "recently" tested positive for COVID-19 and was on contact and droplet isolation during the quarantine period. When V26 was asked when R13 was being isolated in R13's room, did R13 attempt to exit the room, and V26 stated, "Yes, (R13) would be talking about (R13's) little sister and looking for (R13's) little sister." V26 stated that R13 had an agency caregiver sitting outside R13's door in a chair. V26 stated that some agency caregivers would sit outside R13's room in the chair directly in front of R13's door.

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S9999	Continued From page 11 On 6/16/22 at 11:00 am, V8 (LPN) stated that R13 tested positive for COVID-19 last month (May 2022) and was on contact and droplet isolation in R13's room for two weeks. V8 stated that R13 had a caregiver sitting in a chair outside R13's door and that R13 would be knocking on the door and yelling to come out. V8 stated, "We had a chair in front of (R13's) door. The caregiver would move the chair for me (V8) to go in. If the caregiver would have to go to the bathroom, then I (V8) would sit in the chair." V8 stated that the chair would be "pushed against the door to prevent (R13) from coming out." On 6/16/22 at 10:42 am, V27 (PAL Trainer) stated, "R14 did test positive for COVID-19 over a month ago and was isolated in (R14's) room. (R14) would attempt to get out of (R14's) room." V27 stated that a private caregiver would be outside R14's room to "prevent and not let (R14) come out." V27 stated that the caregivers would be outside R14's door and have the chair in front of R14's door and not to the side of R14's door because "there's not much space." V27 stated that while R14 was on COVID-19 isolation, on one or two dates when V27 started working V27's day shift, V27 stated that a chair was wedged up against R14's door (under door handle). V27 stated that V27 would remove the chair because "I (V27) knew that it was keeping (R14) hostage," and V27 told the caregivers that they couldn't do that because it was keeping R14 hostage. On 6/8/22 at 11:46 am, V3 (Memory Programs Coordinator) stated that V3 is responsible for overseeing PALs schedules and assists with training the PALs in the facility. V3 stated that exit seeking behaviors are common for memory care residents. V3 stated that when memory care residents are being isolated in their room for	S9999		

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	IL6016935	A. BUILDING: ____ B. WING ____	06/16/2022

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COVID-19, "They don't understand why they are in there (under isolation in their room)." When asked about staff using a physical object, like a chair, outside the resident isolation door to prevent egress, V3 stated, "It's not acceptable. Technically, I (V3) see that as a restraint. Restraints we don't do here."

On 6/8/22 at 3:31 pm, V20 (Director of Resident Care Services, Sister Facility) stated that no physical barrier should prevent residents from exiting their rooms.

On 6/8/22 at 1:46 pm, V1 (Executive Director) stated that if a resident tests positive for COVID-19 and requires additional assistance, the facility will hire an "outside companion" or care giver that will be outside the resident's door to make sure the resident stays inside the isolation room by watching the door. When asked if a physical object be used to prevent a resident from exiting the isolation room, V1 stated, "No, I (V1) walked past and saw a chair in front of a door. I (V1) called (external agency caregiver company) and told them that to wedge a chair under a doorknob, that is a big no-no. Care givers are to sit by the door and not blocking the door." V1 stated that one of the nurses or PALs had also informed V1 about chairs being used to barricade resident doors, and V1 restated, "I called (external agency caregiver company) and told them that caregivers don't wedge the back of the chair under the door handles." When asked the purpose of not using a chair to prevent a resident's egress from the room, V1 stated, "It's a safety risk, and it's disrespectful. The caregiver can open a door and tell a resident to go back inside. It's humane."

Facility policy, dated June 2003 and titled

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"Restraints," documents, in part, "Policy Statements: (Facility) Assisted Living Community upholds the resident's rights and freedom from restraints ... Restraints will never be used as a convenience for employees."

Facility undated document, titled "(Facility) Alzheimer's Special Care Disclosure Statement," documents, in part, "I. The philosophy of (Facility) concerning the care or treatment of persons with Alzheimer's Disease ... embraces a person-centered philosophy that is ability-centered with a goal to maintain resident functioning at the highest practicable level."

(B)

Statement of Licensure Violation 3 of 3:
330.1530a)

Section 330.1530 Labeling and Storage of Medications
a) All medications shall be stored in a locked area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or room. In those facilities where a licensed nurse dispenses medication to residents, medications may be stored in a locked mobile medication cart, which is made immobile when not in use by the nurse to dispense medication.

These Regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to maintain resident medications stored in a locked cabinet which has the potential to affect fifteen residents residing on

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S9999	Continued From page 14 the 3rd floor of the facility. Findings include: On 6/6/22 at 11:50 am, V11 (Personal Assistant Liaison, PAL) and V12 (PAL) were observed in the 3rd floor dining room setting up for the lunch meal service. This surveyor observed, on top of a dining room buffet table on the south wall, a clear medicine cup containing the following: 2 white, circular, medium sized pills; 1 white, circular, small sized pill; and 1 pink, oblong, large sized pill. This medication cup was located next to a PAL assignment sheet, labeled as "B" with V12's name on the assignment sheet. On 6/6/22 at 12:10 pm, V11 was informed by this surveyor of the observation of the medication cup of 4 pills not stored in a locked cabinet on the dining room buffet table. V11 stated, "I (V11) will notify the nurse." V11 then went back to plating food for residents in the dining room. On 6/6/22 at 12:30 pm, V9 (Corporate Nurse, Licensed Practical Nurse, LPN) entered the 3rd floor dining room and picked up the unattended medication cup of the 4 pills on top of the buffet table. V9 verified with this surveyor that there were 4 pills in the medication cup. This surveyor asked V9 who's medications are in the unsecured medication cup, and V9 stated, "I (V9) don't know." This surveyor asked V9 where resident medications should be stored, and V9 stated, "In the locked medication cart." When asked if medications should be left unattended, V9 stated, "No." V9 confirmed to this surveyor that a PALs assignment sheet was next to the unsecured medication cup, and V9 stated that V9 did not know which PAL had the "B" assignment. V9 then called out to the PALs in the dining room assisting	S9999		

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other residents to find out the PAL assignments, and V12 (PAL) confirmed that it was V12's assignment sheet next to the unattended medication cup. When asked if V12 placed the unsecured medication cup in dining room directly next to V12's assignment sheet, and V12 stated, "No, it's not my job. It's not my job."

On 6/8/22 at 10:43 am, V9 (Corporate Nurse, LPN) stated that the purpose of having medications stored in a locked medication cart is that medications aren't accessible to residents who are at risk of taking medications not prescribed to them or may be allergic to.

On 6/8/22 at 1:46 pm, V1 (Executive Director) stated that all medications should be stored in the locked, central cart on the 3rd floor and that only licensed nurses are allowed to administer medications to residents.

Facility policy dated May 2003 and titled "Medication Management," documents, in part, "Purpose: To assure safe and accurate supervision, assistance and/or administration of medications by a licensed professional acting within the scope of said license. Policy: ... 6. Medications will be stored in a locked cabinet."

Facility roster dated 6/6/22 and titled "Community Census Report," documents, in part, that fifteen residents reside on the 3rd floor of the facility.

Facility undated document, titled "(Facility) Alzheimer's Special Care Disclosure Statement," documents, in part, "I. The philosophy of (Facility) concerning the care or treatment of persons with Alzheimer's Disease ... embraces a person-centered philosophy that is ability-centered with a goal to maintain resident

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S9999	Continued From page 16 functioning at the highest practicable level." (C)	S9999		