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	IL6015911	A. BUILDING: _____ B. WING _____	C 02/18/2025

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BELMONT VILLAGE OAK PARK	1035 MADISON STREET OAK PARK, IL 60302

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S 000	Initial Comments Complaint investigation 2590956/IL 185859- No deficiency Facility Reported Incident of 01/13/2025 /IL185135	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)2) 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. c) The written policies shall include, but are not limited to, the following provisions: 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services, and social services. Based on interviews and record reviews, the facility failed to implement their resident care policies by failing to mitigate risk to patient safety for 1 (R1) of 3 cognitively impaired residents reviewed for resident safety. R1 eloped from the	S9999		

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facility secured memory care unit unsupervised on 01/13/2025 during the winter without proper clothing. This failure affects all 16 residents residing on the memory care unit.

Findings include:

R1 is 82 years of age. Current diagnoses include but are not limited to Dementia, Hyperlipidemia (High Cholesterol), and Hypertension (High Blood Pressure). R1 who is cognitively impaired left the secured memory care unit of the facility unsupervised through the emergency exit door on January 13, 2025. The temperature recorded for the day was 19 degrees Fahrenheit. R1 was found in a restaurant without proper winter clothing.

On 2/10/25 at 10:58 AM, R1 was inquired of leaving the unit unsupervised and going outside the building. R1 said, "I just did what I had to do and left. I don't remember how."

On 2/10/25 at 11:00 AM, V4 PAL Personal Assistant Liaison was inquired of exit doors on 2nd floor and monitoring residents on the memory care unit on 1/13/25. V4 said, "R1 was new, it was the same week he got here. He goes back and forth to the hall bathroom. He'd ask where his room was because the door didn't have his name on it, it still said welcome. We have three exit doors. R1 got out the exit door at the end of the hall. I wasn't assigned to R1, it was V2 PAL. I was coming up the elevator from my lunch and I heard the code. It means a resident eloped. When I came onto the floor, V6 said R1 isn't here, and we checked the rooms and stairwells to make sure she didn't overlook him. V6 went outside with other staff. I stayed on the unit with the other residents. When we go on lunch break

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there's only one caregiver or the nurse on the floor. There's no one that comes when one person leaves for their break."

On 2/10/25 at 11:11 AM, V7 Enrichment Leader was inquired of R1's elopement on 1/13/25. V7 said, " R1 was a new resident, he was trying to navigate his surroundings. I was coming back to the unit from my break and walked into the situation. Over the walkie there was a code for a missing person. Staff were looking for him. There's a alarm on the exit door, it was going off so we knew someone went out the door. I went down the stairs and looked out the door and he wasn't there. The door leads downstairs to the exit outside. The exit door up here isn't locked, there are instructions on the door so if you can read, then you'd be able to get out." V7's 1/13/25 time sheet validates she was no on the unit when R1 eloped.

On 2/10/25 at 11:30 AM, V8 LPN Licensed Practical Nurse was inquired of nurse assignments exit and doors on 2nd floor. V8 said, " The morning shift has two nurses that work three floors. There are six floors with two memory care units. One on second floor and on third floor. There are exit doors on each end of the floor. Those doors say emergency exit, push door for fifteen seconds to open it. I'm not sure if an alarm goes off. It leads to a stairwell and another door goes outside."

On 2/10/25 at 11:43 AM, V5 LPN was inquired of nurse assignments, monitoring residents on the memory care unit, and R1's elopement on 1/13/25. V8 said, "R1 was new to the facility. I did his admission. He'd just walk down the halls looking for his room. He didn't ask to leave or go home. I worked three floors that day, first,

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second, and third. V4 and V6 PALs were assigned to the floor. I wasn't told when they took their break, they don't have to tell me. They tell each other and one stays on the floor. It's hard to keep up with all the staff working three floors. I saw him last during lunch in the dining room. I remember he had on a black shirt, red sweater, pants, socks, and shoes. I was on third floor when I heard the code and his room number. I came down to second floor and started checking the rooms. I didn't hear any alarms; I just saw staff going to the West emergency exit door. It's not locked because it would endanger the residents. The exit door has instructions to push and hold for fifteen seconds then you can open it and the alarm will sound."

On 2/10/25 at 12:30 PM, V8 LPN was inquired of monitoring residents on the memory care unit and R1's elopement on 1/13/25. V8 said, "I wasn't scheduled for his floor. V5 and I were working the floors. I had fourth, fifth, and sixth floors. I was in the wellness center coming from break and I heard the code over the walkie. I went to the front desk to the receptionist. They couldn't find him, so I went out the front entrance of the building around to the back area and came around. I went back into the building and got my coat because it was so cold. I went back out down Madison Street and went door to door to the business. The first building I ran to was the pizza restaurant. There was a police officer going in. I went in and the officer was talking to R1. The owner had called the police. I paged all clear to building when I found him. The restaurant is across the alley on the same side of the street."

On 2/10/25 at 12:49 PM, this surveyor and V8 LPN reviewed the emergency exit door R1 went out of from the second floor and the stairwell

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leading to the second exit door leading out of the building. There is an emergency exit door on each end of the floor. Each door has instructions written on it that says to push door for fifteen seconds to open. Alarm will sound. V8 LPN showed this surveyor the stairwell down to another exit door. The door instructions say emergency use only. This door leads outside the building. Door was opened and no audible alarm was heard.

V6 PAL Personal Assistant Liaison was inquired of monitoring residents on the memory care unit, and R1's elopement on 1/13/25. V6 said, "It was after lunch, R1 was a new resident. He was a wanderer; he'd walk up and down the halls and we'd have to redirect him. He'd pull on other resident's doors. He'd gone to the emergency doors before, but we'd stop him before he'd go out the door. After the resident's lunch I was in the dining room by myself because V4 was on lunch. It's memory care so a lot of residents' wander. I had about 13 to 14 residents for half an hour by myself. V7 Enrichment Leader went to lunch too. We just tell each other when we go to lunch. We have set times for lunch. R1 went to his room. His room is next to the dining room. One of the female residents was in his room using his bathroom. It must have alarmed him because he thought he was in the wrong room. I was trying to redirect the female resident out of R1's room and went back into the dining room. I had my radio on me, but I didn't hear the door going off. V4 Caregiver came back from lunch and asked if I heard the alarm for the door. I went to the door. It says steps to push it and it'll open. R1's smart so he can just read what it says. I went down the stairs to the back of the building and walked around it. V8 LPN came back to the building with R1."

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On 2/10/25 at 1:31 PM, V3 Director of Resident Services was inquired of staffing and R1's 1/13/25 elopement. V3 said, " On 1/13, V4 and V6 PALs were scheduled for the neighborhood. That's memory care. The nurse was V5 LPN Licensed Practical Nurse for second floor. She was assigned first, second, and third floor. R1 moved in 12/27/24. I heard the code and V1 Executive Director called and said we needed to expand our search. The rest of the team was searching the floors and perimeter. The concierge told me the police brought R1 back to the building."

V3 was inquired of the investigation of R1's elopement. V3 said, "V1 and I were in charge of the investigation. I spoke to V9 Director of Activity & Memory Care she said V6 PAL was with another resident providing care and when she came out noticed R1 wasn't around. She searched for him and didn't find him. V6 called the code on the radio. V9 said she spoke to V4 PAL and she helped look for R1. I spoke to V10 Wellness Coordinator about informing R1's family and to place a private PAL with him for the next two days in the event he needs more direction. I spoke to the building manager to make sure all the door alarms worked. I don't remember speaking to V5 LPN. V5 reported to V9, and she charted everything. The hallways don't have cameras."

On 2/10/25 at 2:41 PM, V9 Director of Activity & Memory Care was inquired of R1's 1/13/25 elopement. V9 said, "R1 was a new resident. He was ambulatory. He gets up and wanders but was able to be redirected. We have two PALs on the floor. One stays with the group and the other would go with the resident wandering and walk

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the halls to keep eyes on the residents at all times. We didn't understand his behavior at that time. I was out of the building on lunch when V1 Executive Director called me about the code. I immediately went back and joined the floor and spoke with V6 PAL and V7 Enrichment Leader. V6 said she was in the room with another resident and heard the alarm when she came out. V7 said she heard the alarm for the door. V6 said she and V7 called the code and started doing a head count. V1 called on the radio when R1 was found. I spoke to V4 PAL later to follow up. We put an intervention of a private PAL to be with him from 7AM to 7PM to monitor and make sure he wasn't exit seeking because of his Dementia. I wanted to make sure he did have any behaviors due to his transition. I did a combined summary for each of the staff."

On 2/11/24 at 11:32 AM, V1 Executive Director was inquired of PAL Personal Assistant Liaison lunch schedules and the second floor memory care census. V1 said, "The PALs have scheduled lunch times, and they can see them on their schedule. They clock out and back in for their lunch. We try not to schedule lunch during resident mealtimes, but it depends on the amount of staff and what's going on. Sometimes they don't always go at their time. The typical census was twelve to fifteen residents." The 1/13/25 census was requested for review.

On 2/11/25 at 11:43 AM, V3 Director of Resident Services was inquired of PAL Personal Assistant Liaison lunch schedules and supervision of Dementia residents. V3 said, "There are two PALs on each floor with assigned lunch times. The breaks are thirty minutes. Lunch breaks are before the resident meal times. During this time residents are usually doing activities with V7

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Enrichment Leader. The PAL would let the other PAL, or the Enrichment Leader know they're going to lunch. A PAL can be left on the floor alone with all the residents because it's a secure unit. Dementia residents need redirection and space to move around. It's a secure unit for safety because they don't have the safety awareness to independently move around. Dementia residents may have confusion, be forgetful, need to be reminded, may exit seek, and wander. Those would be reasons to be supervised on a secured unit. Staff is on the unit to redirect and call for assistance. The PAL isn't able to monitor them all by themselves. Our staff need to be aware and respond to their behavior."

On 2/11/25 at 11:43 AM, V3 was asked if a PAL is on the floor alone and in a room assisting a resident, who is monitoring the other residents on the floor? V3 said, "No one is monitoring the other residents, they're on a secure unit."
V3 was asked if a resident on the secured unit needed to be able to read and understand the instructions on the emergency exit door to be able to open it? V3 said, "No, they don't."
The resident care policy for supervision/monitoring was requested for review from V3.

On 2/11/25 at 12:10 PM, V1 Executive Director was inquired of monitoring of the emergency exit doors on the memory care floor and where they led when R1 eloped on 1/13/25. The stairwell from the second floor was reviewed with V1 and V3. V1 said, "We don't have internal cameras or in the stairwells. When you come out the exit door into the stairwell it locks. The only option is to stay in the stairwell until a staff comes or go up or down the stairs. The exit door at the bottom of the stairwell goes outside. R1 went down the

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stairs and out this door. We have a camera in the loading area in the back of the building and saw him. He walked around the back of the building onto Wenonah Avenue up to Madison Street and crossed over to the restaurant. After our investigation, we didn't make any systemic changes. We didn't install any cameras. Our system worked and we were alerted when the door opened. We contacted R1's family and put in interventions for him."

The community census indicates R1 was admitted to the facility on 12/27/24. The 1/13/25 community census report states in part Dementia living second floor 16 residents listed.
The Monday January 13,2025 facility schedule states in part 6:30 AM- 2:24 PM 2 NB (Neighborhood) PAL Personal Assistant Liaison V4 and V6. LPN Licensed Practical Nurse V5 and V8.
The time sheet for V4 PAL indicates a clock out time for lunch at 11:59 AM and back in at 12:33 PM on Monday 1/13/25. The time sheet validates V4's interview regarding being off the floor for her lunch break.
V3 Director of Resident Services provided a wander risk assessment for R1 dated 12/6/24. R1 was not a resident of the facility until 12/27/24.

The 10/01/24 Elopement Procedures policy states in part:
Purpose: To provide a protocol for responding to an elopement from the facility.
Procedure: 1. All residents (AL- Assisted Living and Neighborhood- Memory Care) should be assessed for their risk of elopement within thirty days of admission to the facility.
4. Behaviors that could lead to elopement such as anxiety, agitation, boredom, and pacing should be reported to the nurse.

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The undated Resident Centered Care Policy states:
POLICY: Belmont Village provides Resident-Centered Care, based on the assessment and needs of the resident. An individualized care plan is provided for each resident based upon that assessment.
PROCEDURE:
1. All Belmont Village residents, as a part of their Resident Service Plans, have their individual care needs performed by the PALs as noted by the Approach Charting.

2. A Resident Service Plan may call for frequent checks based on the complete assessment.

3. Additionally, authorized representatives may randomly check the care provided. This is accomplished through various methods, including but not limited to rounding, conversations with residents/families, shift change meetings, daily Stand Up, Transition Meetings, Care Conferences.

The undated Staff Supervision policy states in part:
POLICY:
It is the policy of Belmont to staff based on the functional ADL needs of the residents (including bathing, dressing, grooming, and toileting). Belmont PALS function as 'universal workers', whose work assignment may include personal care, activities, laundry, and light housekeeping duties.

1. PROCEDURES: In Memory Care, supervision is done in conjunction with the MPC (Memory Program Coordinator) /DAMC (Director

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S9999	Continued From page 10 of Activity & Memory Care) and the DRCS (Director of Resident Services) , but may extend to the LPN/nurse on duty if the MPC/DAMC are not on the premises. Additionally, a Lead PAL may coordinate the PAL assignments. 2. Staff are able to reach a member of the management team 24 hours/day, 7days/week. (A)	S9999		