

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2012
NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE GENEVA ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 545 BELMONT LANE CAROL STREAM, IL 60188		
(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
Z 000	COMMENTS Complaint investigation # 1272718/IL58935 - Section 330.1110 a) cited Incident Report Investigation of 8/4/12/ IL58960 - Section 330.710 a), c) 2) cited	Z 000		
Z9999	FINDINGS FINAL OBSERVATIONS LICENSURE VIOLATIONS 330.710 a) c) 2) 330.1110 a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures which shall be formulated with the involvement of the administrator. These written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. They shall be in compliance with the Act and all rules promulgated thereunder. c) These 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. Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of	Z9999		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z9999	<p>Continued From page 1</p> <p>care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on observation, record review and interviews the facility failed to develop policies to determine appropriate care to address elopement and pressure ulcer.</p> <p>This applies to 3 (R4, R5 and R6) of 3 residents reviewed for elopement and 1 (R3) of 3 residents reviewed for pressure ulcer. R4, R5 and R6 had left the facility without staff knowledge and R3 was left without pressure ulcer treatment for undetermined period.</p> <p>Findings include:</p> <p>A.</p> <p>1. R6 was admitted to the facility on 10/29/11 with multiple diagnoses which include abnormality of gait, lack of coordination, confusion.</p> <p>Review of R6's Neuropsychological evaluation dated 11/30/11 indicated under background information that R6 "has a history of severe alcohol abuse, and also has a history of</p>	Z9999			

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Z9999	Continued From page 2 confusion. R6 also has a history of being hospitalized "due to severe delirium as she had been missing for 24 hours, was totally disoriented and unaware of herself and was psychotic." The same evaluation indicated that R6 has multifactoral Dementia characterized by alcohol induced persisting Dementia as well as hippocampal impairment associated with an Alzheimer's disease process. Under recommendations it stated, "she requires 24 hour monitoring and assistance with all activities of daily living." R6's remarks form dated 11/23/11 (2PM) indicated, "Resident observed to walk out the front entrance door into the rain without coat on. Concierge ran out to bring resident back into community." R6 was asked by the staff where she was going and R6 responded, "I don't know?" R6's remarks form dated 4/16/12 (2 PM) indicated that R6 was found on a different floor of the facility (resides on the 2nd floor, was found on the 3rd floor). The same remarks reflected that R6 did not know where she was or where she live, "increase confusion." R6's narrative summary incident report dated 8/11/12 indicated, that at approximately 8:30 AM, E1 (Administrator) received a telephone call from the Police Department that R6 was found walking East bound on North Avenue. On 8/21/12 at 2:35 PM, R6 was inside her room watching television. R6 was asked what she remembered of the incident. Per R6 she was told by her daughter that she walked out of the facility and was found by the Police walking along North Avenue. R6 stated that she does not remember when and why she left the facility. R6 also stated that she was told by her daughter that she was	Z9999			

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Z9999	<p>Continued From page 3</p> <p>found wearing her night gown and gym shoes. R6 stated that she left the facility via the front door, there was no staff present and that there was some light already, "it was not dark."</p> <p>The facility's investigation report reflected that on the night of 8/10/12, after R6 had a shower, R6's daughter took the resident out for ice cream. R6 went out for ice cream wearing her nightgown, gym shoes and coat. The investigation indicated that R6's daughter brought the resident back to her room and observed that R6's bed covers were pulled back.</p> <p>The facility's investigation also indicated that R6's daughter told the facility that R6 complained that her legs were tired on the day of the incident.</p> <p>The facility's investigation report reflected an interview with the Police officer who found R6. The report indicated that a call into the police dispatch was made on 8/11/12 at 7:56 AM, by a person driving by who saw R6 on North Avenue walking East bound. When the officer found R6, she was sitting on a ledge outside of a lounge away from the facility. R6's ID (identification card) inside her purse helped to find R6's daughter, who was contacted by the Police officer.</p> <p>Mapquest indicated that from the facility to the location where R6 was found by the Police on 8/11/12, R6 have walked approximately 1.5 miles away from the facility.</p> <p>On 8/21/12 at 12:07 PM, E12 (PAL/Personal Assistant Liaison) stated that she gave a night shower to R6 on 8/10/12. Per E12, after assisting R6 with her night clothes, R6's daughter came and took the resident outside the facility for ice cream. E12 stated that she does not know when</p>	Z9999			

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Z9999	<p>Continued From page 4</p> <p>R6 came back to the facility. Per E12 on 8/10/12 between 9:00 and 9:15 PM, she was outside R6's room and she heard R6's television on. E12 stated that she did not go inside R6's room to find out if the resident was inside because, R6 at times does not want to be bothered and at times gets upset. According to E12 this is the only time she attempted to check on R6. Per E12 it is part of her duty to check and see her residents before leaving her shift. E12 stated, "I'm suppose to check her to see and make sure that she (R6) is in her room before I leave, but since I heard the television from outside her door, I assume the resident was inside."</p> <p>On 8/21/12 at 2:47 PM, E9 (PAL) stated that he was the staff assigned to R6 on 8/10/12 from 11:00 PM through 7:00 AM of 8/11/12. E9 stated that he did not see and/or check on R6 his entire shift because the resident is independent, "and when I came back to work they told me she was gone.". According to E9, "We are suppose to check on residents that needs assistance, but independent residents are not checked. Now we do, after this incident with R6." According to E9, during his shift on 8/10/12, he stayed at the nursing station by room 216, and if R6 comes out of her room & walk by the hallways, he would be able to see the R6. However, if he is assisting and providing care to residents that needed assistance, he would not be able to see R6 leave the floor. Per E9 he would provide care to residents between 11:00 PM to 12:00 midnight and then every 2 hours thereafter and as needed. E9 stated that he was providing care to other residents between 5:00 AM and 6:00 AM on 8/11/12. E9 stated that he is not aware of R6's history of leaving the facility unescorted nor was he aware that R6 has a history of wandering off the unit.</p>	Z9999		

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Z9999	Continued From page 5 On 8/21/12 at 11:45 AM, E11 (PAL) stated that she was the staff assigned to R6 on 8/11/12 from 6:30 AM to 3:00 PM. Per E11 she did not check on R6 at the start of her shift. E11 stated that the first time she checked R6 on 8/11/12 was at around 7:45 AM. Per R6 she unlocked R6's room door, went inside the room and did not see R6. R6's bed was made up and she assumed that R6 was already having breakfast. E11 stated that she familiar with R6's routine. According to E11, R6 normally stays in bed until 8:00 AM and that she (E11) would normally make R6's bed, so when R6 was not in her room at 7:45 AM, she just assumed that R6 went down for an early breakfast. Per E11, she was bringing another resident to the other unit and she passed by the first floor main dining area to look for R6 when, E1 approached her and told her that R6 was found outside of the facility by the Police. On 8/21/12 at 2:10 PM, E13 (PAL) stated that she worked on the first floor on 8/10/12 from 10:30 PM through 7:00 AM of 8/11/12. According to E13 at around 5:30 AM, the main entrance door alarm was activated and she immediately went to check the door. Per E13 she checked the main entrance door by going out of the 2 main entrance doors leading towards the outside of the facility to the end of the patio area. E13 stated that she also went to the small parking lot in front of the facility, and did not see any resident and/or individual leaving the facility grounds. Per E13, after doing this, she went inside the facility and restored the alarm. According to E13 while inside the front desk area she saw some news papers outside by the patio area, so she decided to go out to pick up the news papers, which again activated the main entrance door alarm. Per E13 after picking up the news paper she went back	Z9999		

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Z9999	Continued From page 6 inside the facility and restored the alarm. E13 stated that she did not see any resident walking outside of the facility when she went outside the second time. E13 was asked what is the facility policy/protocol when the main entrance door alarm goes off. E13 responded that the staff should immediately acknowledge the alarm, should check to see if any resident went out. The staff should go outside of the building to check the patio area and the parking lot, then restore the door alarm after checking. E13 was asked if it is the facility's policy/protocol to report to the nurse after the door alarm was activated. E13 responded that she is not aware that she should inform the nurse when the alarm goes off and no resident and/or no individual was found leaving the facility grounds. E13 stated that she is familiar with R6. Per E13 R6 walks good without the use of any device, she walks in moderate speed. E13 stated that she responded immediately to the door alarm and with the way R6 walk, if the resident (R6) activated the door alarm she (E13) should be able to see her leave the patio or the parking lot area. The facility's computerized alarm records was reviewed with E14 (Maintenance Director) on 8/21/12 at 1:20 PM. The alarm records indicated that the main entrance door was activated on 8/11/12 at 5:22:36 AM and the alarm was restored at 5:23:59 AM. The alarm was acknowledged by E13. The alarm records showed that it took 1 minute and 17 seconds for E13 to restore the alarm. Based on the interview with E13 on 8/21/12 at 2:10 PM, this corresponds to the time the door alarm went off, and E13 went outside the facility to check the patio area and the parking lot area, then go back in to restore the alarm, all in all, it took E13 1 minute and 17 seconds.	Z9999			

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Z9999	<p>Continued From page 7</p> <p>The same facility computerized alarm records showed that on 8/11/12 at 5:23:59 AM, the main entrance door was activated and the alarm was restored at 5:24:11 AM. The alarm was acknowledged by E13. The alarm records showed that it took 12 seconds for E13 to restore the alarm. Based on the interview with E13 on 8/21/12 at 2:10 PM, this corresponds to the time when she (E13) activated the main door alarm to pick up the news papers on the patio.</p> <p>On 8/21/12 at 9:47 AM, E14 stated that once the main door alarm goes off, it sends verbal message to the individual staffs hand held radio announcing that the main entrance door was activated. The staff has to acknowledge the alarm on the hand held radio and the staff has to go to the main entrance door and restore the alarm by pressing the button by the wall on the front desk area. If it is not not acknowledged and restored, the alarm would continue to go off. Per E14, the facility door alarms does not make a sound by the door but sends verbal messages to staff hand held radios.</p> <p>Review of R6's records did not show any wandering or elopement assessment. R6's record also did not show any care plan in place to address elopement and wandering behavior.</p> <p>2. R5 has multiple diagnoses which include Vascular Dementia. On 8/9/12 at 2:20 PM, R5 was observed in the secured unit walking along the hallways. R5 was alert but confused with steady gait.</p> <p>Review of R5's variance report dated 3/21/12 (4:15 PM) indicated, "elopement (from secure area)." The report indicated, "walked out of main</p>	Z9999			

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Z9999	<p>Continued From page 8</p> <p>entrance after wine and cheese. was brought back into building. no injuries." The location of the incident was "Great room parking lot/sidewalk."</p> <p>Review of R5's variance report dated 6/3/12 (4:45 PM) indicated, "Resident was noted in the middle of the street of Geneva Rd. trying to cross to the other side. An employee guided her back in our facility." This report did not indicate any injury to the resident.</p> <p>On 8/9/12 at 2:45 PM, E7 (PAL- 2:30 to 11:00 PM shift) stated that R5 has a wandering behavior. Per E7, R5 would go straight to the lobby to exit the main door when not with a private PAL. E7 stated that R5 is not safe outside the facility without an escort.</p> <p>On 8/9/12 at 2:55 PM, E8 (PAL- 6:30 AM to 3:00 PM shift) stated that R5 has a wandering behavior.</p> <p>On 8/9/12 at 3:00 PM, E9 (PAL- 2:30 to 11:00 PM, at times work 6:30 AM to 3:00 PM) stated that R5 has a wandering behavior. Per E9, R5 would verbalize that her daughter is waiting for her and that she has to go outside. E9 stated that R5 has dementia and is not safe to go outside of the facility without an escort due to poor safety awareness.</p> <p>Review of R5's records did not show any wandering or elopement assessment. R5's record also did not show any care plan in place to address the two incidents of elopement behavior.</p> <p>3. R4 has multiple diagnoses which Dementia. On 8/8/12 at 10:19 AM, R4 was observed inside the Town Hall room, ambulating with steady gait,</p>	Z9999		

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Z9999	<p>Continued From page 9</p> <p>using a rolling walker. R4 stated that he never left the facility without an escort and that he does not remember going to the Shell gas station by himself.</p> <p>R4's narrative summary incident report dated 8/4/12 (approximately 9:30 AM) indicated, "Resident was found by the facility driver at the Shell Gas Station at the corner of Geneva Road and Schmale Road in Carol Stream (located approximately 1/2/ block from the facility)." The report also indicated, "Resident unable to articulate where he was going nor why he left the facility."</p> <p>On 8/9/12 at 1:55 PM, E10 (LPN/Licensed Practical Nurse) stated that R4 requires a staff, family member or an escort to go out of the facility. Per E10, R4 is not allowed to go pass the concierge/front desk area because the resident has dementia and he does not know where to go. E10 stated that R4 is not safe to cross the street independently.</p> <p>On 8/9/12 at 2:05 PM, E11 stated that R4 is not allowed to go pass the concierge/front desk area. Per E11, R4 is not safe on his own outside the facility.</p> <p>On 8/8/12 at 3:30 PM, E1 stated that on the day of the incident on 8/4/12, a concierge orientee was at the front desk and did not know that R4 was not allowed to go out of the facility without an escort.</p> <p>Review of R4's records did not show any wandering or elopement assessment. R5's record also did not show any care plan in place to address the incident of elopement and/or the elopement behavior.</p>	Z9999			

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Z9999	Continued From page 10 On 8/9/12 at 3:40 PM, E1 stated that the facility has residents that are confused and with diagnoses of Dementia. Per E1 the facility does not have any policy to direct the staff with regards to assessment, monitoring and care planning of residents with wandering and/or elopement behavior to determine appropriate care and to ensure resident safety. On 8/21/12 at 4:00 PM, E1 stated that the facility does not have any policy and/or protocol with regards to how often residents are to be checked or monitored during the shift, the facility does not have a policy/protocol with regards to door alarms & staff response to door alarms. On 8/22/12 at 3:30 PM, E1 was asked how often residents are checked by the staff to ensure their (residents) presence and location in the facility for every shift. E1 responded, "it varies." When asked about the specifics, E1 responded, "it just varies," and did not give any further information. (B) B. R3 has multiple diagnoses which include history of stroke with right sided weakness, Depression and Venous Stasis.	Z9999		

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Z9999	<p>Continued From page 11</p> <p>Review of R3's Home health revisit documentation dated 8/3/12 indicated that R3 has the following pressure ulcers:</p> <ul style="list-style-type: none"> - Left heel - unstageable, 100% necrotic tissue, measuring 3cm (length) x 4cm (width) x 0 cm (depth), - Right heel - unstageable, 100% necrotic tissue, measuring 1cm (length) x 0.4cm (width) x 0cm (depth), - Right plantar - unstageable, 100% necrotic tissue, measuring 1cm (length) x 2cm (width) x 0cm (depth), - Left Ischium - Stage II pressure ulcer, 80 % yellow slough, 20 % black eschar, measuring 4cm (length) x 3cm (width) x 0.2cm (depth), - Sacrum - unstageable, 90% black eschar, 10% red granulation, measuring 8cm (length) x 8cm (width) x 0.2cm (depth). <p>R3's remarks form dated 8/4/12 (no time documented) indicated, "In bed turned & repositioned frequently, drsg (dressing) to coccyx area came off. HH (Home Health) nurse will stop by to apply new drsg."</p> <p>On 8/9/12 at 11:47 AM, E3 (LPN) stated that on 8/4/12 at around noon time, R3 was wet and needed to be changed. When the PAL (Personal Assistant Liaison) turned R3, the dressing on the resident's sacral/coccyx area came off. According to E3, she called Z2 (home health Director of Nursing) and informed her (Z2) that R3's pressure ulcer dressing came off. Per E3, Z2 informed her that she (Z2) will be coming to the facility as soon as she can to apply a new treatment. E3 added that R3 did not have any dressing supplies and had requested Z2 to bring in more. E3 stated that during her entire morning shift (6:30 AM - 3:00 PM), she did not apply any dressing and/or treatment on R3's sacral/coccyx</p>	Z9999			

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Z9999	<p>Continued From page 12</p> <p>area, because there was no available dressing supplies. Per E3 she was the nurse on duty when R3 was sent to the hospital. E3 stated that she does not remember if R3 had any dressing on the sacral/coccyx area or left ischial area when the resident left the facility to the hospital on 8/5/12. E3 also stated that she did not receive any endorsement from the previous shift if a new dressing was applied to the resident since the sacral/coccyx area dressing was removed in the morning of 8/4/12.</p> <p>On 8/9/12 at 12:50 PM, E4 (LPN) stated that she was the nurse on duty on 8/4/12 during the 3 - 11 shift. Per E4, Z2 came to see R3 on 8/4/12 around 7:30 PM. E4 stated that she received endorsement from E3 that Z2 will be coming in the evening of 8/4/12 to apply dressing on R3's sacral area. E4 stated that she did not check to see if Z2 applied the pressure ulcer treatment on R3 when she (Z2) came that evening. According to E4, she did not do any treatment and/or did not apply dressing on R3's sacral ulcer on 8/4/12 during her shift because there was no available dressing supply. According to E4, if there were dressing supplies available, she will apply the treatment on R3's sacral pressure ulcer.</p> <p>On 8/9/12 at 12:25 PM, E5 (LPN) stated that she was the nurse on duty on 8/4/12 from 10:30 PM to 7:00 AM (8/5/12). Per E5 she did not receive any endorsement from the previous shift regarding absence of dressing on R3's sacral ulcer. E5 stated that if a resident's pressure ulcer dressing came off, she would call the home health nurse to apply a new treatment because, the nurses in the facility does not do any treatment and/or dressing of resident's pressure ulcer. Per E5, she did not apply treatment and/or dressing on R3's sacral ulcer during her shift.</p>	Z9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2012
NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE GENEVA ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 545 BELMONT LANE CAROL STREAM, IL 60188		
(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
Z9999	<p>Continued From page 13</p> <p>On 8/9/12 at 11:05, Z2 stated that she received a call from E3 on 8/4/12 to bring dressing supplies for R3. Per Z2 she was never informed that R3's sacral ulcer dressing was removed. Z2 stated that on 8/4/12 at around 7:30 PM, she came to the facility to deliver dressing supplies for R3 but she did not do any pressure ulcer treatment and/or dressing on R3's sacral ulcer.</p> <p>On 8/20/12 at 11:15 AM, E6 (PAL) stated that on 8/5/12, she provided incontinence care to R3 at around 7:30 AM. Per E6, during this time R3 had a patch (dressing) on the tail bone area. E6 stated that at around 9:00 AM, R3 had a bowel incontinence that soiled the tail bone patch, so she removed the patch. Per E6 she told E3 to look at R3's pressure ulcer, after she finished cleaning the resident but she failed to inform E3 that she removed a dressing on R3's tail bone area. According to E6, she does not know if she was allowed to remove the dressing on R3's wound. However, E6 stated that she should have informed the nurse when she removed the tail bone dressing on 8/5/12. Per E6, R3 was sent to the hospital on 8/5/12 without dressing on the tail bone area.</p> <p>On 8/9/12, Z1 (physician) stated that R3 was totally non-compliant with regards to pressure ulcer treatment and prevention. R3 refuses to elevate her legs and refuses to release pressure off her sacral area. Per Z1, R3's left and right heel and right plantar area were necrotic but intact, therefore no treatment and/or dressing were needed. R3's left ischium had an order for "maxorb AG with exoderm" dressing twice a week and R3's Sacral area had an order for "Optifoam" dressing twice a week. According to Z1, the "Optifoam" dressing on R3's sacral area provides</p>	Z9999		

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NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE GENEVA ROAD			STREET ADDRESS, CITY, STATE, ZIP CODE 545 BELMONT LANE CAROL STREAM, IL 60188		
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Z9999	Continued From page 14 mild debriding and adds cushion to the sore. Z1 stated that if a resident's dressing came off, the facility should follow there protocol/policy to determine appropriate action. On 8/9/12 at 3:40 PM, E1 and E2 (Director of Nursing) both stated that the facility does not have a policy regarding pressure ulcer to determine the appropriate action, care and services needed when a resident's pressure ulcer treatment and/or dressing was removed and home health nurses are not available to apply new treatment and/or dressing. (B)	Z9999			