STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	C 08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

(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) COMPLETION DATE
W 000	INITIAL COMMENTS COMPLAINT INVESTIGATION 1694337 \ IL87435 W153 W154 COMPLAINT INVESTIGATION 1694678 \ IL87812 No deficiencies.	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to ensure 1 of 1 incident of physical aggression involving R1 was reported to Public Health. Findings include: The Incident Report dated and timed 8/1/16 at 8:30pm, involving R1 was reviewed. It states that R1 had a behavior with physical and verbal aggression and property damage. In the notification box, a date of 8/1/16 was marked next to the police box. The narrative reads that R1 had been re-directed, due to R1 entering an area he was not allowed to go into(female's room). R1	W 153		

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

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W 153	Continued From page 1	W 153		

physically overturned furniture and small objects that were placed inside of his room. R1 was separated from his roommate, and other clients, until R1 could calm down.

The nursing notes for R1 were reviewed. The entry dated 8/1/16 at 8:30pm states that R1 was sitting next to R2, and had been re-directed numerous times to stop following R2, but R1 was insistent, stating that R2 was his "woman". R2 was escorted back to her room by staff, and R1 came into her room. Staff told R1 to leave, and that is when R1 left, and went into his own room in a hostile rageful state of mind. R1 turned over all of his dressers onto the floor, and smaller objects were thrown out into the hallway. Md was called and informed about the behavior, and an order to administer Haldol 2mg(milligrams) was ordered for one dose only. R1 still attempted to enter R2's room, and was not accepting any re-direction, so the local Police Department was called. Two police officers came to the facility, and spoke with R1, telling R1 he should not enter R2's room. The note states the police arrive around 10:00pm and stayed until approximately 10:30pm. At this point, R1 was in his room and was quiet when the police left the facility.

The investigative narrative, authored by E5(Facility Manager), dated 8/1/16 was reviewed. It states that on 8/1/16, R1 was experiencing behaviors during the afternoon-pm shift. R1 was saying that another female resident(R2) was his girlfriend/wife, and that staff was not allowed to touch her, and not allowed to tell him what to do. When staff intervened while R1 was attempting to inappropriately touch R2, R1 became verbally aggressive, and non-complaint with staff. R1 attempted to enter R2's room, and as staff

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W 153	Continued From page 2 re-directed R1, he became physically aggressive(turning over furniture inside of his room, throwing objects out of his room, into the hallway), and was shouting loudly to staff, telling him to leave him alone. Nursing was notified, and R1 was separated from other clients as well as staff to ensure safety, until R1 could calm down. and relax. Staff closely monitored R1 for approximately 45 minutes after the incident, to ensure safety. During an interview with E1(Administrator) on 8/10/16 at 1:00pm, E1 was asked if this incident was reported to Public Health, as there is no indication in their report that it had been reported., or that the police department was out at their facility to assist in calming R1 down. E1 stated that he had not reported it, and that was a mishap on his part. E1 stated that he was home sick at the time of the incident, and it was just an over sight.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure 1 of 1 incident of physical aggression was thoroughly investigated, involving R1 and R2. Findings include: R1 was observed in his bedroom, lying down in his bed on 8/17/16 at 11:30am. R1 was observed to be calm, and told this surveyor that he missed	W 154		

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W 154	Continued From page 3 the van to Day Training, and that was why he was home today. The Incident Report dated and timed 8/1/16 at 8:30pm, involving R1 was reviewed. It states that R1 had a behavior with physical and verbal aggression, and property damage. In the notification box, a date of 8/1/16 was marked next to the police box. The narrative reads that R1 had been re-directed, due to R1 entering an area he was not allowed to go into(female's room). R1 physically overturned furniture and small objects that were placed inside of his room. R1 was separated from his roommate, and other clients, until R1 could calm down. The nursing notes for R1 were reviewed. The entry dated 8/1/16 at 8:30pm states that R1 was sitting next to R2, and had been re-directed numerous times to stop following R2, but R1 was insistent, stating that R2 was his "woman". R2 was escorted back to her room by staff, and R1 came into her room. Staff told R1 to leave, and that is when R1 left, and went into his own room in a hostile, rageful state of mind. R1 turned over all of his dressers onto the floor, and smaller objects were thrown out into the hallway. Md was called and informed about the behavior, and an order to administer Haldol 2mg(milligrams) was ordered for one dose only. R1 still attempted to enter R2's room, and was not accepting any re-direction, so the local Police Department was called. Two police officers came to the facility, and spoke with R1, telling R1 he should not enter R2's room. The note states the police arrive around 10:00pm, and stayed until approximately 10:30pm. At this point, R1 was in his room and was quiet when the police left the facility.	W 154		

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W 154	Continued From page 4 The investigative narrative, authored by E5(Facility Manager), dated 8/1/16 was reviewed. It states that on 8/1/16, R1 was experiencing behaviors during the afternoon-pm shift. R1 was saying that another female resident(R2) was his girlfriend/wife, and that staff was not allowed to touch her, and not allowed to tell him what to do. When staff intervened while R1 was attempting to inappropriately touch R2, R1 became verbally aggressive, and non-complaint with staff. R1 attempted to enter R2's room, and as staff re-directed R1, he became physically aggressive(turning over furniture inside of his room, throwing objects out of his room, into the hallway), and was shouting loudly to staff, telling him to leave him alone. Nursing was notified, and R1 was separated from other clients as well as staff to ensure safety, until R1 could calm down. and relax. Staff closely monitored R1 for approximately 45 minutes after the incident, to ensure safety. Per clarification with E1(Administrator) on 8/10/16 at 1:00pm, this is their formal investigation of the incident involving R1's physical aggression on 8/1/16. There is no mention of the police department being called, or that the physician was called, and prescribed medication to calm down R1's behavior. There is no mention of any staff being interviewed, nor who the staff person was who called the police department. During an interview with E5 on 8/10/16 at 1:00pm, E5 explained that she was the staff person who completed the facility investigation involving R1 on 8/1/16. E5 was asked if she was aware the police were called, since it was not included in her investigation. E5 stated that she was not sure about the police involvement. E5 stated that she is not sure who called them, but she thinks it was	W 154		

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W 154	Continued From page 5 nursing. E5 stated that she was made aware the day after the incident that the police were called. E5 stated that she is not sure what R1's behavior was like when the police arrived, or how long they stayed. E5 stated that some staff were formally interviewed, but she did not include their interviews in her report.	W 154		