STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015911	A. BUILDING: _____ B. WING _____	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE OAK PARK	1035 MADISON STREET OAK PARK, IL 60302

(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 Incident Investigation IRI of 3-4-15/IL75557	Z 000		
Z9999	FINDINGS Statement of Licensure Violations Section 330.1110 f) Medical Care Policies The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition. Based on interview and record review the facility failed to notify the physician of a change in behavior for one resident at risk for wandering and elopement (R1) of three residents reviewed for behavior. Findings include: R1 was admitted to the facility 10/31/14 and had been residing on the 6th floor designated as an "unsecured" unit until 3/4/15 when she was admitted to the 3rd floor locked Memory Care Unit. Incident Investigation Summary dated 3/4/15 indicates that at 11:05am (E10), Concierge radioed a "Code" to indicate a resident was missing because at that time a Community Police Officer presented (R1's) name to the Concierge and asked if she was a resident at the facility because she was found at a nearby hospital. Summary also indicates that E2, Director of Resident Care Services and E3, Memory Program Coordinator went to the hospital to pick up R1 and walked with her back to the facility..	Z9999		

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Z9999	Continued From page 1 Nurse's Notes dated 11/9/14 at 10:20am indicates R1 in room alert and confused. Nurse's Notes dated 11/9/14 (no time documented) indicates R1 in room accompanied by family, is noted to be confused and needs monitoring. Nurse's Notes dated 11/10/14 at 6pm indicates R1 noted with anxiety, refused meal and made verbal threats to exit building. Nurse's Notes dated 1/7/15 at 2:00pm indicates "(R1) is unable to self-medicate at this time. There are multiple medications in her room - unlocked. (R1) doesn't know what the (medications) are for, how to take them or why to take them." Nurse's Notes dated 3/4/15 at 11:35am indicate R1 wandered off the premises to the hospital. Upon assessment no injuries noted, Temperature 98.6, Heart Rate 78, Respirations 16 and Blood Pressure 113/62. Note indicates R1 was moved immediately to the locked unit with Physician and family aware of move. Physician Encounter Summary/Assessment and Plan dated/amended 11/6/14 indicates R1 with some progression of Dementia and acute Delirium during a recent hospitalization. Summary indicates R1 needs increased supervision and structure and that R1 socially isolates, forgets to eat and needs ongoing medication administration. Note further indicates R1 has "wandered a few times and would be better in a unit that is locked or supervised."	Z9999		

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Z9999	Continued From page 2 On 3/12/15 at 4:15pm Z4, Physician stated that she discussed medication administration with R1's family when R1 was admitted and was under impression that R1's family was giving R1 her medications. Z4 stated, "R1 was clearly not able to manage her own medications when she was admitted." Z4 further stated that R1 should not have had unsecured medications in her room. At that time Z4 stated that if R1 had been able to manage her own medications and then was found that she had a change in her ability to safely manage medications, she would want to be notified and might determine R1 required a change in her plan of care. Z4 stated she was not notified of the change in R1's function documented in Nurse's Note dated 1/7/14. On 3/12/15 at 9:40am E11, Certified Nursing Assistant (CNA)/Personal Assistant Liaison (PAL) stated, "Everyone knew that (R1) wandered, the nurses, DON, everyone. We all knew (R1) didn't belong on that floor." On 3/11/15 at 4:10pm E3, Memory Program Coordinator stated, "In retrospect the change in (R1's) ability to manage her medications could have signaled a change or decline in her functional abilities and would have warranted closer supervision and re-assessment." On 3/13/15 at 9:36am E11, Personal Assistant Liaison (PAL) assigned to R1 on 3/4/15 stated that she received report from the night shift PAL that R1 had been up all night pacing in and out of her room. E11 stated that she escorted R1 down to breakfast and after breakfast R1 returned to the 6th floor. E11 stated that as residents were getting back on the elevator after scheduled activity , R1 was agitated attempting to go back down on the elevator. E11 stated that staff were	Z9999		

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Z9999	Continued From page 3	Z9999		

trying to redirect R1 away from the elevator because they knew she wandered, was agitated and wanted to leave. E11 stated after all the activity residents were off the 6th floor, R4 (6th floor resident) approached staff wanting to speak with his nurse.
E11 stated that E4, Licensed Practical Nurse (LPN) was then called to report R4's request and to notify of R1's agitated behavior and at that time R1 walked back to her room. E11 stated she then went to help another resident on the 6th floor and was in their room approximately 10 minutes. E11 stated that when she came out of the residents room she saw E4 who asked her to get R1 from her room and when she went to get R1 she was not in her room. E11 stated at that time E4 called down to the Front Desk to ask if R1 was on the 1st floor. E11 stated that as E4 was calling the Front desk she went down the elevator to the first floor and saw the Police Officer and heard the "Code" being called. E11 also ststed that R1 had a "Personal Companion" that stayed with R1 from morning until early afternoon "about four days a week," however the companion was not there on 3/4/15, the day R1 eloped from the facility.

On 3/12/15 at 10:45am E5, PAL stated that at approximately 9:30am on 3/4/15 R1 was pacing and stating that she wanted to go home."

On 3/12/15 at 12:00pm E7, PAL stated that E5 approached him while on the 1st floor and stated that R1 was agitated. E7 stated that when he saw R1 she appeared angry, paranoid and stating, "I'm leaving."
E7 stated that he then escorted R1 into the elevator and onto the 6th floor where E11 was and released R1 to E11 and then rode the elevator down to the 5th floor. E7 was not sure what time of the morning it was that day but was

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Z9999	Continued From page 4 "after breakfast and before lunch." On 3/11/14 at 2:20pm E4 stated that she was notified by phone that R1 was agitated and when she went up to the 6th floor to check on R1, E11 told her R1 was not in her room. E4 stated that she then called down to the 1st floor Concierge to see if R1 was on 1st floor when she heard "Code" being called. TimeandDate.com/Historic Hourly Chicago Area Weather website indicates High Temperature on 3/4/2015 between 6am and 12pm to be 21 degrees Fahrenheit and Low Temperature to be 19 degrees Fahrenheit. On 3/10/15 at 3:20pm E1, Executive Director stated that they were not sure how R1 got out of the building on 3/4/15, however they believe it was through the Terrace Room Exit door while R5 had been outside smoking. E1 further stated that it was possible that R5 had the code to the door. On 3/10/15 at 4:15pm R5 stated that she saw another female resident outside and tried to "wave her in" and stated it was cold. R5 appeared to be reluctant to discuss smoking outside the door and refused to give any more information stating, "I don't want to be involved or have my name used." On 3/12/15 at 9:25am E2, Director of Resident Care Services stated that the PAL's are supposed to document on the Daily Monitoring sheets if a resident doesn't sleep all night or has unusual behavior. "They (PAL's) should have documented that R1 didn't sleep the night before she eloped and that she was agitated." On 3/10/15 and 3/11/15 R1 was observed on the	Z9999		

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Z9999	Continued From page 5 3rd floor locked unit. R1 was unable to discuss events of her elopement and was oriented only to person. The facility failed to notify the physician of the change in R1's ability to self-administer medications and failed to document behavior changes for R1. Facility Policy/Transition From Assisted Living to Dementia Neighborhood Reviewed/Revised 7/03 indicates: 1. Upon observation or apparent change of resident's cognitive functioning, he/she will be reassessed to determine if they are appropriate for the Dementia Day Program. (B)	Z9999		