STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	C 09/08/2021

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) COMPLETE DATE
Z000	COMMENTS COMPLAINT 2196011/IL137248 & 2196105/IL137368 W122 Client Protections cited	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.700a) 350.700b) 350.700c) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record reviews and interviews, the facility neglected to: 1) Ensure the supervision level was increased for 1 client (R1) who left the building at least 11 times since 7/7/2021. In three of those incidents R1 required police interventions to get him back to the facility. On 7/19/2021, the facility was not	Z9999		

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Z9999	Continued From page 2 aware R1 eloped; 2) Ensure staff report incidents of elopement to the Administrator and Illinois Department of Public Health; and ensure elopements involving the local police are reported to the resident's guardian 3) Ensure management identifies which staff are able to arm and disarm the door alarms. R1 (on 7/19/2021) and R2 (on 8/21/2021) both eloped from the facility without the door alarms going off. Findings include: The Wandering and Elopements policy revised March 2021 was reviewed. Under Policy Interpretation and Implementation is includes; "...3) If a resident is missing, initiate the elopement / missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass; b. If the resident is not authorized to leave, initiate a search of the building and premises; and c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies. 4) When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. Notify the resident's legal representative; d. Notify search teams that the resident has been located; e. Complete and file incident report; and f. Document relevant information in the resident's medical record."	Z9999		

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Z9999	Continued From page 3 1) R1's incident report of 7/20/2021 at 7:32pm was reviewed. Under description of incident it includes; "Resident eloped from the facility and was followed by staff who tried to convince him to return to the facility. Resident refused to return to the facility and crossed the street without looking, putting himself at (in) danger. The decision was made by staff who was following him to call the police for assistance...". Another incident of R1 dated 8/22/2021 was reviewed. It includes under describe the incident; "After being asked by writer if he would like to call his mother on the phone and stating he can't, resident exited the building via the front door. Writer accompanied resident and asked him where he was going. Resident replied, "By my mom." After multiple attempts to redirect resident, resident continued to walk out of facility parking lot and on to the sidewalk of Eastern Ave. accompanied by writer. After about 15 minutes resident decided that he would come back in to the facility and read his book." After review of R1's incident report, surveyor reviewed R1's record. His nursing notes includes the following: "8/22/2021 5:30pm Resident continuously (continued) walking out of door un-escorted into parking lot... resident non-compliant with rules and regulations of facility... 8/19/2021 10:30pm ...ran out of building end up on Eastern Ave. and St. Charles, Bellwood Police returned with him in the squad car... 8/16/2021 11:00pm ...He ran out of the building onto Eastern Ave. Staff returned with him at	Z9999		

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Z9999	Continued From page 4 8:35pm... 8/12/2021 10:00pm ...left out of building several times throughout shift but was easily directed back inside with verbal cues... 8/11/2021 11:00pm ...at 7:25pm, he kept trying to exit the building, staff had difficulty redirecting him. He ran out of the front main door. He was observed walking south on Eastern Ave... 8/04/2021 10:00pm ...Ran out of the building with staff in pursuit... 8/04/2021 2:30pm ...Multiple episodes of leaving out of the building with staff having to follow him and persuade him to return to building... 8/03/2021 10:00pm ...Resident did leave the building x 3 during this shift but was directed back inside without incident... 7/7/2021 11:00pm ...He ran out of building, remained in front lawn x 40 minutes..." R1's record was reviewed. A nursing note dated 7/19/2021 10:30pm, includes; "...8:15pm, a female neighbor came to our front door to report that she saw a person (male) walking south on Eastern Ave. Several staff got in their car to look for R1, 2 more staff checked all outdoor areas. Bellwood Police were notified. He was found on Eastern Ave near Butterfield Rd. walking on east side of Easter Ave. Returned accompanied by Bellwood Police and DSP (Direct Support Person)..." In order for R1 to get to where he was found, he had to cross the intersection of Eastern Ave. and St. Charles Road which does have a traffic light.	Z9999		

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Z9999	Continued From page 5 Review of the facility's incident report revealed that no incident report for this date can be found. E2, Director of Nursing, was interviewed on 8/25/2021 at 1:13pm. E2 stated, "I didn't even know about this one. E11 (nurse) should have notified me at least because our policy is to notify everybody." E2 then verified that R1's guardian was not notified of this elopement. Surveyor showed E2 the nursing notes on the 7/19/2021 incident. E2 stated, "This was written by E11 (nurse). She has been working here for many years now and she knows that she should have notified me at least about the incident because policy is to notify everybody." E2 was re-interviewed again on 8/27/2021 at 11:00am about why there are no incident reports for the other dates that were documented in the nursing progress notes. E2 stated, "We do not make an incident report if he did not leave the property. We only have a report once R1 leaves the property. Surveyor asked why there was not an incident report for 8/19/2021 when R1 was picked up by the Bellwood Police at the intersection of Eastern Ave. and St. Charles Rd. E2 answered, "I am not aware of that incident. We don't know if staff was aware he eloped and staff was with him." E12, Supervisor, was interviewed on 8/31/2021 at 10:41am. E12 stated, "For the incident of 7/19/2021, I was working that day. I believe it was the nurse that told me someone came here to let us know he (R1) was seen walking on Eastern Ave." E12 added, "No one knew he was missing. We don't know how long he was missing." "To my knowledge, no one knew R1 was missing until that lady came." Surveyor asked if anyone heard	Z9999		

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Z9999	Continued From page 6 the door alarms going off. E12 answered, "Not to my knowledge." E12 further added, "For the 8/19/2021 incident, "I think he ran out. Staff was aware that he ran out around 6 or 7pm." E12 was asked why an incident report wasn't made and not reported to management. E12 answered, "I don't know who was supposed to write the incident report. Is it the nurse, myself or the staff?" E12 was asked if R1's supervision has been changed since the multiple incidents of elopement. E12 answered, "He is not on any special monitoring. R1's supervision is like everyone else's supervision." E4, Residential Services Director, was interviewed on 8/27/2021 at 10:45am. E4 stated, "I wasn't aware that R1 eloped on 7/19/2021." Surveyor asked who should write the incident report. E4 answered, "An incident report should have been made by staff and nursing." R1's record was reviewed. A nursing note dated 8/19/2021 at 10:30pm, includes; "...ran out of building and end up on Eastern Ave, and St Charles, Bellwood police returned him in the squad car, he refused to ride in van driven by E12 (Supervisor)..." Review of the facility's incident reports revealed that no incident report for this date could be found. E2, Director of Nursing, was interviewed on 8/27/2021 at 11:00am. E2 stated, "I am not aware of that incident." Surveyor asked if staff knew the moment he left the facility and was monitoring him the whole time. E2 answered, "We don't know that staff was with him." E2 verified that	Z9999		

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Z9999	Continued From page 7 R1's guardian was not notified of the incident. The facility incidents were reviewed for R1's elopements. The incident reports for the 7/20/2021 and 8/22/2021 elopements were the only incident reports available. R1's behavior tracking form for the months of June, July and August for his elopements were reviewed. No data was recorded except for 8/11 which documented 4 times and 8/20 which documented 5 times. The documentation does not identify if R1 left the building or was attempting to leave the building. R1's elopement protocol dated 8/3/2021 was reviewed. It includes the following: >If team member noticed that R1 has left the building: =Team member should call for assistance. =Team member should try and redirect R1 to re-enter the building. =If R1 does not enter the building Team members should follow him to ensure his safety. =If R1 is unsafe, Team members should call 911 immediately and call the supervisor on duty. >if R1 leaves the building and without any Team members noticing that he left: =A systematic search of R1's care units and other immediate areas =A thorough search of the grounds =Notification of management, family members and physician =Notification of local police to request their assistance =Documentation of all actions taken either at the time of the incident or immediately afterward Surveyor interviewed E2, Director of Nursing, on	Z9999		

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Z9999	Continued From page 8 8/24/2021 at 11:02am. E2 stated, "All doors are alarmed. R1 just walks out the front door. He has a diagnosis of Dementia/Alzheimer's and when the sun sets is when he tends to elope. Staff is always behind him." Surveyor asked how the doors are alarmed and disarmed. E2 answered, "Once the receptionist leaves (around 7:30pm), she verifies that the alarm is on. It is now in a lock box. The receptionist leaves the key to the nurse. There is only one key in the building. The nurse can then hand the key to someone she can designate to arm and disarm the doors." Surveyor asked if they facility identified staff that can be designated to arm and disarm the door alarms or if any staff can do it. E2 answered, "No we don't have a list of people that they can designate." E2 added, "I also want to see who can disarm the doors as I don't know how to do it." 2) The facility's undated incident follow up was reviewed. It includes; "On 8/21/2021 at approximately 8:20pm, Direct Support Person (DSP) E16 report to E3 (Assistant Director of Nursing) that they were looking and unable to locate R2. E3 immediately had the staff do a search of all the rooms of the facility. While he and E17 (nurse) proceeded to do a bed check to ensure that resident wasn't in another room. E3 then searched the entire exterior perimeter of the building including the grounds to no avail. At approximately 8:45pm, Bellwood Police called by E3 to report resident missing..." The Bellwood Police Incident Report dated 8/21/2021 at 9:03pm was reviewed. The summary includes; "According to staff at Bellwood Developmental Center, R2 has an	Z9999		

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Z9999	Continued From page 9 intellectual disability and is "selectively mute". R2 walks slowly with an unsteady gait...At approximately 12:13am (8/22/21) prior to arrival of the drone team, Z1(Police Officer) located R2 just feet away from train tracks north of the facility, behind an electrical box, in an area covered by tall grass and approximately 30 feet from an overflow creek. R2 was laying on her side with her head towards the tracks...". E2, Director of Nursing, was interviewed on 8/27/2021 at 11:00am. E2 stated, "I interviewed all the staff present when R2 eloped, no one heard the door alarms go off." E2 was asked if someone checked if any of the doors were disarmed. E2 answered, "No, I did not check if any of the doors were disarmed." (B)	Z9999		