

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015911	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/03/2019
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NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE OAK PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1035 MADISON STREET OAK PARK, IL 60302
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S 000 Initial Comments

Annual Licensure Survey

Complaint Investigation:

1992430/IL00111003

- 1891203/IL00100524 - no findings
- 1991433/IL00109919 - no findings
- 1897026/IL00106869 - no findings
- 1897737/IL00107637 - no findings
- 1796589/IL00098044 - no findings
- 1892010/IL00101404 - no findings
- 1890974/IL00100273 - no findings
- 1990897/IL00109327 - no findings

S 000

S9999 Final Observations

Statement of Licensure Violations

- 330.710 a)
- 330.710 b)
- 330.780 c)
- 330.1110 f)
- 330.1110 g)
- 330.4240 a)

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.

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Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public.</p> <p>Section 330.780 Incidents and Accidents.</p> <p>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. 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.</p> <p>Section 330.1110 Medical Care Policies</p> <p>f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition.</p> <p>g) At the time of an accident, immediate treatment shall be provided by personnel trained in medically approved first aid procedures.</p> <p>Section 330.4240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These Requirements were NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to appropriately follow up with care of 1 (one) of 5 residents (R4) reviewed for falls in the sample of 9. This failure affects R4 who had an unwitnessed fall and was not sent to the hospital until 12:40pm and was diagnosed as having acute intracranial hemorrhage and intraventricular hemorrhage.</p> <p>The facility also failed to send the final investigation report to the Regional Office within 7 days allowed for investigation</p> <p>Findings include:</p> <p>R4's medical record showed that R4 is a 96 years old resident with chronic condition of Dementia and physical condition that includes but not limited to recent left hip surgery and bilateral hip replacement.</p> <p>R4's facility fall assessment presented (with no date) indicated that R4's total score is 9 which categorized R4 as a Moderate Risk Score.</p> <p>On 4/2/19 at 4:30am, V14 LPN (Licensed Practical Nurse) documented, in part, R4 had a fall incident. R4 was found on the floor in the room laying on the left side next to the bed. V14 was unable to determine when R4 fell and how long R4 was on the floor. V14 stated that PAL's (Patient Assistant Liaison) makes round every hour but the nurses don't really have a rounding schedule.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>V14 documented R4 answered "No" to the question of hitting (R4)'s head during the fall and whether R4's head is hurting. V14 documented R4 was able to move all extremities, was placed in the wheel chair, assisted to the toilet and then placed in bed. V15 (Family) was notified.</p> <p>V9 (LPN) documented at 8:30am, in part, that R4 was up in the wheel chair for breakfast, took all scheduled medications, but refused to eat breakfast. V9 documented was unable to get the pulse oximetry because R4 refused to keep the device on. R4 was not sent to the local hospital until 12:40pm for evaluation.</p> <p>On 7/3/19 at approximately 2:12pm, V14 stated R4 had an unwitnessed fall on 4/2/19 at 5:30am and upon assessment R4 did not sustain any injury. V14 stated R4 was found at 5:30am not at 4:30am as documented in the incident report saying "that was an error on my part." V14 stated R4 stated R4 did not hit head during the fall and was not hurting when asked. V14 added there was no apparent injury because R4 was able to move all extremities without difficulty. V14 stated "I notified the family and the physician through the fax." When V14 was asked about the facility protocol on responding to unwitnessed falls with residents who have diagnosis of Dementia, V14 replied R4 says (R4) did not hit the head and was not hurting, there was no bumps and no bruising.</p> <p>On 7/3/19 at approximately 10:30am, V9 stated during shift change on 4/2/19 V14 reported that R4 had a fall during the night shift and R4 was okay with no injury. V9 explained that R4 did not eat breakfast and lunch. V9 stated because V15 stated that was no injury that was why R4 was just being monitored. V9 further explained that at lunch time R4 did not want the lunch but was</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>sleepier than usual and not talkative as usual. Vital signs were taken and then the ambulance was called with the family's consent to send R4 to the local hospital for evaluation. V9 stated the family came into the building during this time and they escorted R4 to the emergency room. V9 acknowledged having gone thru the dementia training and stated because of the dementia I would have sent R4 to the hospital by calling 911 (the emergency line) because at times it is difficult to determine whether they (referring to residents with a dementia diagnosis) have an injury or are actually answering the question correctly.</p> <p>V1 (Administrator) stated R4 was not sent to the hospital because of fall it was because of change in status. V1 stated R4 was not eating or talking and was lethargic. V1 did not relate the fall to R4's change in status.</p> <p>V12 (Memory Program Coordinator) stated there is nothing to investigate, the Resident R4 has Dementia.</p> <p>R4's local hospital emergency department documentation dated 4/2/19 showed that R4 has a minimally raised contusion to the left temporal region and CT (Computed Tomography) of the Brain without IV (Intravenous) contrast was done. The Preliminary Result showed "Acute intracranial hemorrhage in the left frontal and parietal lobes. Intraventricular hemorrhage involving the lateral and third ventricle. Blood products are also noted in the bilateral ambient cisterns."</p> <p>On 7/3/19 at approximately 10:45am, V2 (Director of Nursing) stated during emergency the staff are to follow the policy and procedure on falls, not to get them up and the nurses will have to decide</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>whether to send the resident out by calling 911. When asked about the reasons for not sending R4 to the hospital for evaluation and treatment when the fall occurred, V2 explained that sending residents to the hospital is based on case by case just because they have dementia does not mean they cannot answer. The surveyor then asked what about in R4's case with Chronic condition of Dementia, V2 then stated R4 should have been sent to the hospital properly because that's what I would have done.</p> <p>On 7/3/19 at 3:57pm, surveyor called V16 (physician) and was unable to speak with physician.</p> <p>On 7/1/19, 7/2/19 and 7/3/19 (three days of the survey) the facility did not present any policy and procedure on falls and emergency care of falls with Dementia residents. V12 then presented an Employee Handout on staff at the facility responding to Resident or guest falls dated April 2019 which listed seven steps to follow if a resident or guest fell not addressing the resident with Dementia population or resident with cognitive impairment to avoid delay in treatment or cause injury.</p> <p>R4 had a fall on 4/2/19 and the facility did not fax the final summary report to the Regional Office within seven days after the occurrence as required until 4/11/19. When V1 (Administrator) was asked about reporting the incident, V1 did not answer the question just nodded her head.</p> <p>(A)</p>	S9999		
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