STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016935	A. BUILDING: _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE LINCOLN PARK	700 WEST FULLERTON AVENUE CHICAGO, IL 60614

(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
S 000	Initial Comments Complaint Investigation: 2388274/IL165130	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4240a) 330.4240b) 330.4240d) Section 330.4240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) These requirements were NOT MET as evidenced by: Based upon record review and interview the facility failed to follow their elder abuse policy and procedures, failed to document resident IOUO (Injury of Unknown Origin), failed to ensure that staff report IOUO to the Executive Director and/or designee, failed to notify State Agency of IOUO within regulatory requirements, failed to ensure that the Date of Occurrence reported to State Agency was correct and failed to ensure that the	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 incident category includes sexual abuse for one of three residents (R1) reviewed for abuse. These failures have the potential to affect 121 residents. Findings include: The (10/ 5/23) census includes 121 residents. On (10/4/23) State Agency received abuse allegations that someone touched (R1) inappropriately on 10/2/23 at night. (R1) has bruising on the inner thigh and is scared to return to facility. R1's diagnoses include Alzheimer's disease and Dementia. R1's (October 2023) MOCA (Montreal Cognitive Assessment) determined a score of 13 (Moderate Cognitive Impairment). R1's (October 2023) care plan affirms assistance is required for changing continence products, personal hygiene, and changing clothing. On 10/10/23 at 10:28am, surveyor inquired about R1's cognitive and functional status V4 (LPN/Licensed Practical Nurse) stated "She's oriented times 1-2. She needs assistance with dressing. She has a caregiver every day." Surveyor inquired if R1 has ever made false allegations against a resident and/or staff V4 responded "No." Surveyor inquired who are abuse allegations are reported to V4 replied "We should report it right away to the administrator and our supervisor." On 10/10/23 at 10:32am, surveyor inquired about concerns with R1. V6 (Caregiver) stated "She	S9999		

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S9999	Continued From page 2	S9999		

(R1) got two (2) bruises here (pointing to right thigh) I noticed when she went to the bathroom. I told the PAL (Personal Assistant Liaison/V5) about the bruises on September 28th and she, (V5) called the Nurse to tell her. On 10/3/23, she (R1) went to the doctor for complaint of arm pain, and we noticed choking when she was eating. When the doctor said is there anything else? She (R1) said last night (10/2/23) somebody came and tried to touch me. She (R1) said he or she ran out of the room. The doctor said you can't go back home until we find out what's going on here and she (R1) was sent to the hospital."

R1's (10/3/23) progress notes state resident went out at 1:30pm for appointment with primary care physician. Resident has not returned. At 7pm, writer called Medical Center for update. Resident being held for further evaluation at emergency room. [R1's 9/28/23 bruises are excluded].

On 10/10/23 at 10:40am, surveyor inquired if R1 was touched inappropriately R1 nodded her head yes. Surveyor inquired where R1 was touched R1 laid on the bed and slapped her left buttock. Surveyor inquired if a man or a woman touched her inappropriately R1 stated "I don't know."

On 10/10/23 at 12:30pm, surveyor inquired about R1's (9/28/23) reported bruises V2 (DON/Director of Nursing) stated "We spoke to the NOD (Nurse on Duty) about that day, the Agency Nurse (V11) doesn't remember anything." Surveyor inquired why V5 (PAL) didn't report R1's bruises to administration V2 responded "She (V5) was there yes but doesn't report that. The Nurse should do the report and that was not done." Surveyor inquired when R1's (9/28/23) reported bruises were investigated V2 replied "The investigation started 10/3/23 because we didn't have that

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S9999	Continued From page 3 reported. (V5) reported it to the Nurse. It was not reported by the nurse, so we (administration) didn't know about it." On 10/10/23 at 1:26pm, V5 (PAL) stated V6 (Caregiver) made her aware of R1's bruises on "Thursday" (9/28/23) and she (V5) immediately told V11 (Agency Nurse). On 10/10/23 at 1:37pm, surveyor inquired about R1's recent abuse investigation(s) V12 (Memory Program Coordinator) stated "I did not know about the bruising until we were told by the (Hospital) Nurse that called and said she (R1) was being admitted. V9 (Licensed Practical Nurse) called (V2/DON-Director of Nursing) and said (R1) was being admitted because she (R1) reported that someone hurt her here or got hurt here. We were notified on Tuesday night (10/3/23) that (R1) reported someone touched me. (R1) stated it happened Monday night (10/2/23). The bruising on 9/28/23 was reported to the Nurse (V11) that day but we (administration) didn't know about it. When I talked with (V5/PAL) during interview she told me it was bruising reported on Thursday (9/28/23) which she reported to the Nurse (V11). The caregiver (V6) reported it to the Nurse (V11) on Thursday as well." R1's (initial) facility reported incident states Date of Occurrence (10/3/23) which is incongruent with the actual date of either occurrence (re: bruises, inappropriate touch). Incident Category: Injury of Unknown Origin however Sexual Abuse is excluded. Incident description: resident went to physician visit 10/3 in afternoon. POA (Power of Attorney) informed Nurse that resident was being held at hospital for further testing and bruising. IDPH was notified 10/4/23 (7 days after bruises	S9999		

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S9999	Continued From page 4 were reported). On 10/11/23 at 10:06am, surveyor inquired about reporting R1's recent abuse allegation(s) to the State Agency V1 (Executive Director) stated "We reported it within 24 hours when we found out about that." Surveyor inquired about the regulatory requirement for abuse allegations V1 responded "We (facility) have to report it within 24 hours, and we did." Surveyor inquired why R1's bruises were not reported (9/28/23) when the staff were made aware V1 replied "The caregiver (referring to V5) reported it to the Nurse like she (V5) should have done but the Nurse (V11) did not report it. That Nurse (V11) did not communicate it to us (administration), she (V11) should have reported it. She (V11) should have made us (administration) aware." Surveyor inquired if V11 documented R1's (9/28/23) bruises V1 stated "No." Surveyor inquired why R1's Facility Reported Incident Date of Occurrence states "10/3/23" when R1 reported the inappropriate touch occurred the prior night and R1's bruises were reported 9/28/23 V1 responded "I put on it, the date that we were made aware that's the date that I put on there when I fill out a report." Surveyor inquired about R1's Actual Date(s) of Occurrence(s) V1 replied "If you look at the bruise reported to the Nurse (V11) it was on the 28th (5 days prior)." On 10/11/23 at 10:41am, surveyor inquired if any concerns were reported by R1 on 10/2/23 V14 (PAL) stated "She (R1) came out in the dayroom at 3:00 in the morning crying. She told me she was trying to get to her husband, and she was wet." V4/LPNs (10/4/23) statement regarding 10/2/23 shift affirms (R1) was up and changed at 7am.	S9999		

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S9999	Continued From page 5 She (R1) was crying and walking. V5/PALs (10/4/23) statement affirms "Last Thursday" (9/28/23) V6 (Caregiver) asked if I (V5) noticed any bruising on (R1). The Nurse had (R1) pull down her pants to see the bruising. Bruising was on the inside of her thigh above the knee. There was also a bruise on (R1's) hand. V8/PALs (10/4/23) statement affirms on 9/28/23 (R1) showed (V8) a bruise on her hand and a bruise on her thigh above the knee. V16/PALs (10/4/23) statement affirms on Monday (10/2/23) V6 (Caregiver) asked about (R1's) bruises but (V16) told her (V6) to follow-up with the Nurse because it was reported. V6/Caregiver (10/4/23) statement affirms on (10/3/23) when (R1) went to an appointment she (V6) reported (R1) has bruises on her arms, legs, and hands. The doctor asked (R1) "anything else?" (R1) stated that last night (10/2/23) someone came into my room and started to touch me. She (R1) said someone touched her on the bottom and she started screaming." V9/LPNs (10/3/23) statement affirms the POA disclosed that (R1) was being held over at (Hospital Name) for further testing. POA used terms "Serious problem" and "Inappropriate touching by overnight staff." R1's (10/3/23) history & physical states patient presenting to emergency room today due to concern for elder abuse at her nursing home. Patient states she has noticed more bruising on her body recently but is not able to recall how she got these bruises. Patient also endorses someone coming into her room last night and	S9999		

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S9999	Continued From page 6	S9999		

touching her buttocks. Patients' caregiver endorses finding bruises on patients right inner thigh last Wednesday. Additionally, caregiver endorses bringing patient to her primary care physician at which time patient endorsed "Someone at the nursing home inappropriately touched her buttocks (did not slap or hit patient) at which time I screamed and then that person left the room." Patient and caregiver do not feel safe with patient returning to nursing home at this time until this is investigated, or they are able to find new placement for her.

R1's (final) facility reported incident category includes IOUO [sexual abuse is excluded]. Date of Occurrence: 10/3/23 (remains incorrect).

On 10/11/23 at 3:24pm, surveyor inquired if R1's (10/2/23) sexual abuse allegation (re: inappropriate touching) was reported to IDPH V2 (DON) stated "No, we did not know about that. It was a bruise that was reported to us." [Staff interviews/statements affirm inappropriate touching was reported and/or documented during this investigation].

The elder abuse policy and procedure (reviewed 9/29/23) states all employees are expected to follow this policy. Residents who have suspicious bruising, particularly of the face, arms, abdomen, and shins will have such bruising assessed by nursing and a variance report completed with investigation procedure followed. Any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source must be reported to the employee's immediate supervisor who will report such to the Executive Director immediately or it can be reported directly to the Executive Director. When an alleged violation, suspected case of mistreatment,

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S9999	Continued From page 7 neglect or any form of abuse is reported to the Executive Director or his/her designee, they will notify the following persons or agencies of such incident: State Licensing and Certification Agency. The following information should be reported: Date and time the incident occurred, and type of abuse that was committed (verbal, physical, sexual, neglect, etc.). Upon receiving reports of physical or sexual abuse the licensed Nurse shall be assigned to immediately examine the resident. Findings of the examination must be recorded in the resident's medical record and on the resident complaint action form. A person shall not knowingly: fail to report an incident of mistreatment or offense. The results of all investigations shall be reported to the state survey and certification agency withing five (5) days of the reported incident. (B)	S9999		