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 _____	C 12/24/2025

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BELMONT VILLAGE OAK PARK	1035 MADISON STREET OAK PARK, IL 60302

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S 000	Initial Comments Facility Reported Incident of 11/24/25/IL199077 - 330.710c)3)H)	S 000		
S9999	Final Observations Statement of Licensure Violations Section 330.710 Resident Care Policies c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: H) Fostering and maintaining resident safety, dignity, self-determination, and choice. (Section 3-206.05 of the Act) This requirement is NOT MET as evidenced by: Based on interviews and records review, the facility failed to monitor and supervise a cognitively impaired resident with history of exit seeking behavior. This deficient practice applied to one (R1) of three residents reviewed for supervision and resulted in R1 leaving the facility unsupervised. Findings include: R1 is an 86-year-old, male, admitted in the facility on 02/28/25 with diagnoses of Chronic Kidney Disease, Dementia, Hypertension and Osteoarthritis.	S9999		

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R1's resident assessment and service plan dated 11/11/25 documented:
Redirection and Guidance - Requires occasional reminders and cuing
Instructions: provide occasional daily reminders, cuing and routine wellness checks thru shift
Cognitive: MOCA (Montreal Cognitive Assessment) test score is 13, which means moderate cognitive impairment.

Incident report dated 11/24/25 recorded that R1 who resides in a non-secured area of the community exited through an exit door on 11/24/25 at 1:32 PM, walked towards nearby hospital area and was escorted back to facility by hospital staff at 1:35 PM. R1 was assessed and no apparent injuries noted. He (R1) was brought to activities and was calm and engaged. No further wandering or exit seeking behaviors noted when he (R1) returned.

On 12/23/25 at 10:46 AM, R1 was observed in room, watching television (TV). He is alert, oriented with bit of confusion. He was asked on how long he's been in the facility, stated for two days now (per records, admission date was 02/28/25). He is able to stand up and walk with walker independently. He was also asked regarding incident that he got out of the facility unsupervised, stated he does not remember.

On 12/23/25 at 10:55 AM, V5 (Personal Assistant Liaison, PAL) was asked regarding R1 and incident on 11/24/25. V5 replied, "He is alert, oriented with a little bit of confusion; walks with use of walker. I was not working at the time he eloped. He is not actually a wanderer but if they don't walk him back to his room after meal, he gets confused. He will wander around the floor.

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He's not really a wanderer but he needs redirection. This is not a locked unit, no codes needed to staircases and elevators. But if someone use the stairs, it will go off on our radio." Observed V5 opened the exit door, radio announced "Stairwell 407". V5 continued, "PALs can hear and able to check who opened the exit door. I remember that incident as I heard it that when he (R1) left, he used the stairway. They found his walker right there." Observed V5 opened the exit door by room 429, radio announced "Stairwell 429."

On 12/23/25 at 11:30 AM, V8 (PAL) was interviewed regarding R1's incident on 11/24/25. V8 stated, "I was the PAL at the time. He was in the TV room by the elevator, watching TV. He was placed there after lunch. By 1:30 PM there will be activities and enrichment leader will be there. Staff from fifth and sixth floors at the time brought residents to fourth floor." R1 is a resident on the fourth floor in the facility. V8 further stated, "There were only two PALs assigned to fourth floor at the time, me and V9. One of the residents from sixth floor asked me to bring her to the bathroom. By the time I went out, R1 was not in the TV room. I checked his room, his bathroom, then I heard from the radio that he was already missing. I looked for him, everywhere, we went to his bathroom again, the bathroom in the hallway, staircases by 407 then we heard from the radio that he was found outside. He got out of the facility alone. He is alert, oriented, confused at times. he always goes to the first floor. So, we have to redirect him. I always take him to his room. He's not really a wanderer. There are times that he does not know where to go. But he always goes to his room and first floor." V8 was asked on what interventions should be implemented on R1. V8 verbalized, "He needs redirection; make sure

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he is okay; make sure he is dressed; make sure he is toileted; and check on him constantly. This is not the first time that he got out of the facility. One time, I was on another floor and had to come up to attend to one of the residents. I looked into the window and saw him (R1) walking towards the hospital employee parking lot. I told V10 (Enrichment Leader), and she confirmed it was him. We went downstairs to get him."

V9 was also asked on 12/23/25 at 11:46 AM regarding R1's incident. V9 mentioned, "I was working on 11/24/25. He (R1) was downstairs, and we brought him up. He was with V8 initially and was watching TV. I was also with another resident at the time. I believed the alarm was going off and nobody acknowledged it, I was with another resident. We had one radio that day and we left it by the TV. I didn't hear the radio. Normally, there is an enrichment leader to start the activity but at the time, nobody was there. He (R1) needs redirection, direct supervision, he moves fast. Whenever I had him, I keep him with me all the time."

Wandering potential assessment dated 11/11/25 recorded a score of 5 which means caution potential. He is encouraged to attend community activities. The assessment also recorded that R1 sometimes talks about "going to work" and may try to go out the front door but is redirectable.

On 12/23/25 at 1:04 PM, V4 (Wellness Coordinator) was asked regarding R1. V4 replied, "He came February 2025. He was very active as far as walking around, focused to wanting to get to his car. We had to do a lot of redirections with him. Like when he was in the terrace room where they will have communion twice a week. There are times he will sit for communion and after

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communion, he would see the cars in the parking lot, and he will attempt to go out. Staff usually redirect him. He can be redirected but needs constant redirection. He needed supervision and monitoring. His unit is the AL (assisted living) part where they had activities in between meals. On 11/24/25, I was the floor nurse at the time. I got call that R1 had left the building, but he is back and now sitting in the kitchen dining room. I was on the sixth floor and came down the stairs and asked the kitchen staff on what happened. They said hospital staff knocked the kitchen door and brought him (R1) back inside the facility. I did assess him, took vitals and asked him what happened. He said, "I wanted to get out." so he got out. No injuries noted, vitals were within normal limits, and he was okay. I am not aware of any prior history of elopement. He is usually not observed outside, but by the door inside the building. He cannot leave facility unsupervised; family or staff should be with him when he is outside."

On 12/23/25 at 1:32 PM, V10 confirmed during interview that they (V8 and V10) both saw R1 outside the facility. V10 verbalized, "I recognized him because he was carrying a carrot stick for the hand, it was him walking fast towards the backdoor coming from the hospital employee parking lot. We went to get him. He came from outside. I asked him how he got out; he said to read the sign in the door that if press it will open for 15 seconds. He was able to get out."

Facility's policy titled, "Elopement Procedures" dated 10/01/2024 stated in part but not limited to the following:
Purpose: To provide a protocol to an elopement from the facility. Although residents in AL (Assisted Living) are generally free to leave the

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S9999	Continued From page 5 community, the resident's physician may stipulate that the resident is not allowed to leave unsupervised. There were no other policies presented by facility related to supervision and monitoring as requested. (B)	S9999		