

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2026
NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE GLENVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 GOLF ROAD GLENVIEW, IL 60025		
(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 2692315/IL200375	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.1145p) 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. Section 330.1145 Restraints p) No form of seclusion shall be permitted. This requirement was not met as evidence by: Based on interview and record review, the facility failed to remove a resident from the transportation vehicle after transporting the resident to a medical appointment for one (R1) of three residents reviewed for safe transportation and seclusion. Findings include: On 3/13/2026 at 1:50 PM, V3 said that V3 does take care of R1. V3 said that V3 does not work on	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 Tuesdays. V3 said that V3 heard about R1 being left in the car. V3 said the residents are kept in the dining room during meals and activities. V3 said there is a staff monitoring the residents. On 3/13/2026 at 2:09 PM, V4 (CNA-Certified Nurse Assistant) said that V4 was the CNA working with R1 on 2/10/2026 that R1 was left in the vehicle after returning from her appointment. V4 said that V4 got R1 ready for the appointment. V4 said that the driver took R1 to the appointment. V4 said that usually when residents return from their appointments, the front desk will call to notify the staff, and staff will go down to pick up the resident. V4 said that on this day, the front desk called the unit asking if R1 was back. V4 said that he heard that R1 was left on the bus. On 03/13/2026 at 2:24 PM, V1 (EXECUTIVE DIRECTOR OF NURSING) said that V1 was made aware by the facility wellness coordinator that R1 was found in a vehicle by a staff member around 2:00 PM. V1 said that V2 (Director of Nursing) was told at the same time V1 was told. V1 said that V1 went to talk to the driver and staff member that reported the incident while V2 went to check the resident and the nursing staff. V1 said that the staff member that saw R1 in the vehicle heard knocking on the window of the vehicle and when the staff member looked inside the car, the staff member saw the resident. V2 said that the staff member alerted the nurse, and the nurse in turn called the front desk to get the keys from the driver. V2 said that the driver went and brought the resident out of the car. V2 said that V2 interviewed the driver. V2 said that the driver said that he was preoccupied with other things he had to do as he was bringing R1 back to the facility. V2 said that the driver said that he parked at the back of the building, got out without	S9999		

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S9999	Continued From page 2 checking the back of the vehicle. V2 said that V2 can't recall exactly how long R1 was left in the vehicle. V2 said R1 must have been in the vehicle for more than one hour. V2 said that according to timeanddate.com, temperature was 66 degrees for High and 52 degrees for low. V2 said the incident happened during midday. V2 said that the driver was subsequently suspended right there and was terminated six days later. V2 said that the driver did not return to work after his suspension. R1 is a 73-year-old female with a diagnosis of history of stroke. R1's resident assessment and service plan dated 1/20/2026 indicated that R1 is non-verbal related to stroke. Review of the facility log indicated that R1 had an appointment outside the facility on 2/10/2026 at 10:45 AM and was signed out at 10:15 AM. Reviewed Relias training on Provide Safe Transportation with release date of 1/1/2024. This training indicated that "the person's safety and comfort during transportation is main priority. Unable to provide policy on resident safety. Unable to provide information. (A)	S9999		