

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015564	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER BELMONT VILLAGE GENEVA ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 545 BELMONT LANE CAROL STREAM, IL 60188		
(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 Annual Licensure Survey Complaint Investigation: 2671496/200004	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710c)3)A)B)C) 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: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education and training of nurses and other direct resident care providers in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling and on safe lifting policies and techniques and current lifting equipment.	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 C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. These requirements were NOT met as evidenced by: Based on interview and record review, the facility failed to prevent a resident from falling out of bed during cares. This applies to 1 of 3 (R1) residents reviewed for falls in a sample of 8. Findings include: On 02/24/26 at 3:41 PM, R1 said she was being changed by the caregiver when suddenly, she fell. R1 said she fell out of the right side of the bed. R1 said she would not be able to turn herself as she did not have control over the left side of her body. R1 said she had left-sided weakness and if her leg started slipping, she did not have strength or control to prevent her leg from falling over the edge of the bed. R1 said her fall should not have happened. R1 said she hit her head and went to the hospital. R1 said she was afraid of falling out of bed during incontinence care. On 02/24/26 at 2:19 PM, V5 (Caregiver) said he was the caregiver providing incontinence care for R1 the day she fell. V5 said R1 needed assistance from one staff for incontinence care and she had left-sided weakness. V5 said R1 had a halo side rail. V5 said he entered R1's room and had an incontinence brief and towels and was providing perineal care. V5 said he	S9999		

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S9999	Continued From page 2 turned R1 away from him and noted R1 had a bowel movement and left her facing the window, turned onto her right side. V5 said he turned around and walked away from R1 to get the incontinence wipes, which were a few feet away. V5 said he heard R1 saying "help!" as she was slipping out of the bed. V5 said R1 was not hurt but went to the emergency room for a few hours and returned to the facility. On 02/24/25 at 2:36 PM, V6 (LPN/Licensed Practical Nurse) said she was the nurse on duty and was administering medications when she received a call from V5 to get help. V6 said when she went to R1's room, R1 was already back in bed. V6 said V5 told her R1 had a fall after he turned her towards the right side and turned to grab washcloths, then he saw R1 was almost halfway to the floor. V6 said she assessed R1 and saw there was mild redness on the occipital region, so she called the paramedics for R1 to go to the hospital to be evaluated. V6 said when providing incontinence care, staff should have all their supplies gathered and should not walk away from the residents if they are turned, as this could lead to a fall. V6 said R1 did not have the strength to hold her leg if she started to roll over the edge. V6 said when providing incontinence care, you need to turn the resident towards you and if turning them away, the resident should be pulled closer to the staff so there is room, and they are kept in the center of the bed. On 02/25/26 at 1:14 PM, V10 (Caregiver) said when providing incontinence care, she would ensure she had everything ready, and when turning them, she would turn the residents towards her to be a barrier from the residents	S9999		

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S9999	Continued From page 3 rolling out of bed. V10 said prior to R1's fall, she needed two staff for incontinence care. V10 said R1 had weakness to her left leg and would not be able to stop herself from falling if her left leg was over her right leg. V10 also said she would place the resident flat on their back before walking away from them because they could fall out of bed and should not turn their back on the resident if they are rolled to the side. On 02/25/26 at 1:25 PM, V11 (Caregiver) said when providing incontinence care, she would get all her supplies ready before starting. V11 said they would not walk away from the residents during care. V11 said the staff should not walk away from the residents if they are turned onto their side while in bed as they could fall out of bed. On 02/25/26 at 2 PM, V2 (Director of Patient Services) said the caregivers should gather all their supplies prior to starting incontinence care. V2 also said the staff should utilize the residents' strong side when deciding which direction to turn the resident. R1's face sheet showed she was admitted to the facility with diagnoses including anxiety, cerebrovascular accident, depression, hyperlipidemia, hypertension, hypothyroidism, and insomnia. R1's initial assessment showed R1 required assistance with changing incontinence products and/or assistance with personal hygiene. R1's Incident Report dated 2/3/26 showed "On the morning of February 3, 2026 at approximately 7:00 am, caregiver [V5] was providing morning care and observed resident rolling out of bed.	S9999			

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S9999	Continued From page 4 Caregiver immediately called for the nurse on duty ...Nurse [V6] assessed resident and resident reported she hit the back of her head. Nurse called EMS (Emergency Medical Services). EMS transferred resident to [Hospital] for further evaluation ...Resident returned back to the community with all test negative and no new orders at this time." R1's Variance Report dated 2/3/26 showed "Pal [V5] call NOD (Nurse On Duty) to room and said resident fell on the floor, while he was changing the resident Pal turned her position to [right] side, then he went to bathroom to get wash cloths. When he back from bathroom he saw resident falling out of the bed, her and hold the resident as much he can to prevent injury. Resident states doesn't hurt, denies pain. Called 911 and sent to [Hospital]" The facility's Resident-Centered Care policy reviewed 2/2026 showed "All [Facility] residents, as a part of their Resident Service Plans, have their individual care needs performed by the PALS as noted by the Approach Charting." The facility's Fall Management policy reviewed 05/2025 showed To mitigate resident risk of injury from falls by identifying risk factors and applying individualized interdisciplinary fall management strategies. These strategies and interventions will take into account the resident's functional, physical and cognitive status, environmental factors and medical conditions, while fostering the resident's safety, optimal functional level, independence and quality of life. (B)	S9999			