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 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE OAK PARK	1035 MADISON STREET OAK PARK, IL 60302

(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 Facility Reported Incident of 9/6/2021- IL138086	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.710a) 330.710c)1)3)A)B)C)D)E)F)G) 330.710d)1)2) 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. c) The written policies shall include, but are not limited to, the following provisions: 1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances. E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury. F) Development of 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. G) Consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed	S9999		

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S9999	Continued From page 2 to incorporate that equipment when developing architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs. (Section 3-206.05 of the Act) d) For the purposes of subsection (c)(3): 1) "Health care worker" means an individual providing direct resident care services who may be required to lift, transfer, reposition, or move a resident. 2) "Nurse" means an advanced practice nurse, a registered nurse, or a licensed practical nurse licensed under the Nurse Practice Act. (Section 3-206.05 of the Act) These requirements were NOT MET as evidenced by: Based on interviews and record reviews the facility failed to follow their fall reduction policy by not completing fall risk assessments upon admission, every six months, and as needed for residents who were potentially at risk for falls due to behaviors and medical conditions. This failure applied to two (R1 and R2) fo three residents reviewed for accidents. Findings include: 1. R1 is an 80 year old male with diagnoses including: Dementia, Benign Prostatic Hyperplasia, Bipolar Disorder, and Hypertension who was originally admitted to the facility 05/28/2019. R1's progress notes dated 09/06/2021 documented that V5 (Personal Assistant Liaison -	S9999		

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S9999	Continued From page 3 PAL) reported that R1 leaned over in his wheel chair and fell out, hitting his head on the floor sustaining lacerations to his right eye. R1's physician communication form dated 09/06/2021 documents that R1 leaned over and fell out of wheelchair, sustained a laceration over right eye and was sent to the hospital. Incident report summary dated 09/08/2021 documents: on 09/06/2021 at approximately 1:15PM the caregiver V5 (PAL) was pushing R1 in wheelchair when R1 stood up and fell from the chair, hitting head. The caregiver called the nurse, the nurse assessed the resident who noted a laceration to his head. R1 was sent to the hospital and returned on 09/06 with a diagnosis of (closed head injury, initial encounter, laceration of right eyebrow, fall), instruction given for R1 to follow up with primary care physician for suture removal on 09/13/2021. Staff involved include V3 (Licensed Practical Nurse) and V5. 2. R2 is a 71 year old male with diagnoses including: Dementia, Diabetes, and Parkinson's Disease who was originally admitted to the facility 02/27/2021. 10/13/2021 at 10:05AM Observed R2 with a brace on left foot; R2 was non-interviewable. 10/13/2021 at 10:33AM V5 (Personal Assistant Liaison) stated that R2 fractured foot while in the facility and the cause of his fracture is unknown. R2's history and physical dated 02/09/2021 documents under neurological status as having myoclonic jerks. R2 incident report summary dated 07/17/2021	S9999		

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S9999	Continued From page 4 documents: on 07/17/2021 at approximately 9:45AM the caregiver witnessed R2 fall out of a chair in the common area and hit his head on the floor. R2 was transported to the hospital. R2 returned to the facility 07/17/2021 with a diagnosis of (contusion of right temporofrontal scalp), initial encounter. R2's progress notes dated 09/07/2021 7:20AM document that V5 (PAL) reported R2 was walking toward her, knee locked and buckled and fell to the floor hitting head, sustaining a laceration over right eye; paramedics were called and head was cleaned; was transferred to the hospital. R2's physician communication form dated 09/07/2021 documents R2 was walking and leg began to lock and buckle under causing fall to floor hitting head sustaining a laceration over right eye; R2 was sent to the hospital. R2's progress notes dated 09/09/2021 3PM documents it was reported by physical therapist that while attempting to assist the resident with ambulation there was swelling observed of his left ankle and foot; physician notified; new order received for x-ray; Director of Resident Care Services notified. R2's physician communication form dated 09/10/2021 documents he was observed with left foot and ankle swelling and was sent out to the hospital for x-rays. R2's progress notes dated 09/10/2021 9:00AM document: (2) PAL's (Personal Assistant Liaison) called nurse to R2's room reporting that R2 had left foot and ankle swelling and was then evaluated and sent to the hospital; R2 returned from the hospital with a diagnosis of closed	S9999		

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S9999	Continued From page 5 fracture of distal end of left fibula, unspecified fracture morphology, initial encounter. Incident report summary dated 09/14/2021 documents on "09/10/2021 at approximately 12:00PM R2 had a witnessed fall on 09/07 while he was walking in his room with a caregiver present. R2 sustained a head injury and was transported to the hospital. R2 returned to the facility 09/07 with no new orders and no new diagnosis. On 09/10 R2 was observed to have a swollen ankle and was transported to the hospital. R2 returned to the facility 09/10 with a diagnosis of (joint swelling, closed fracture of distal end of left fibula, unspecified fracture morphology, initial encounter). Orders received to follow up with an orthopedic surgeon. Staff involved include V3 (Licensed Practical Nurse) and V5. 10/13/2021 at 2:23PM V2 (Director of Resident Care Services\Nursing) stated R2's face sheet states R2 has Parkinson's but she doesn't believe has Parkinson's and is not on any Parkinson's medications. V2 stated R2's history and physical dated 02/09/2021 does document his neurological status with myoclonic jerks. V2 stated R2's need for two person assistance during activities of daily living depends on the day because sometimes R2 is mobile and steady and sometimes R2 is not. On 10/14/2021 at 3:22PM V2 (Director of Resident Care Services\Nursing) stated the origin of R2's fracture was never determined. 10/13/2021 at 10:47AM V3 (Licensed Practical Nurse) stated that R2 fell on 09/07 and she sent out to the hospital. V3 stated the incident occurred during the time she was passing	S9999		

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S9999	Continued From page 6	S9999		

medications. V3 stated a PAL (Personal Assistant Liaison) called her upstairs and stated R2 was coming towards her then began jerking, and before she could assist, fell and hit head. V3 stated she then observed blood on R2 and called paramedics to have R2 transported to the hospital. V3 stated R2 returned during the 2nd shift with no sutures, just and open and cleaned wound with a small bandage. V3 stated R2 was kept in a wheel chair after the incident for precautions due to shaking and inability to stand. V3 stated on 09/09 R2 was sent out to the hospital again. V3 stated R2 has Parkinson's so shaking is often. V3 stated R1 had a fall 09/06. V3 stated R1 was in wheel chair with V5 (PAL) present and fell. V3 stated she then sent R1 out to the hospital. V3 stated R1 had a laceration over right eyebrow as a result which required 8 sutures. V3 stated R1 was in wheel chair inside room with V5 present. V3 stated during that time residents were being taken to their rooms to be toileted or changed. V3 stated V5 reported R1 fell out of wheelchair and fell on face.
10/13/2021 at 1:08PM V5 (PAL) stated on 09/06 while transferring R1 in wheelchair to his room to be toileted, R1 leaned over and placed feet hard on the floor and then leaned forward and fell forward out of the chair. V5 stated R1 had a history of leaning forward in the chair. V5 stated interventions in place for R1 during that time included reminders to sit back in wheelchair. V5 stated R1 often takes feet of the foot rests and also has a history of dragging foot on the heel when being transported by wheelchair . R1 requires constant redirection. V5 stated on 09/07 she was in R2's room preparing a towel to clean face after dressing him. V5 stated R2 was sitting on the side of his bed. V5 stated R2 then stood up and began exhibiting jerking movements while attempting to ambulate towards her. V5 stated R2

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S9999	Continued From page 7 often exhibits jerking movements related to his Parkinson's. V5 stated she was unable to brace R2's fall because of her distance from R2 at the time and R2 fell on the floor towards side, hitting eyebrow area on the right side. V5 stated there were no prior issues or interventions in place for fall prevention related to R2's Parkinson's. V5 stated 09/09, while R2 was being tested for a lift device, the physical therapist noticed left foot and ankle were swollen. V5 stated when R2 fell 09/07, R2 did not give any indication to pain in his foot. V5 stated during the fall on 09/07, R2's foot did not encounter anything and path was clear. 10/13/2021 at 1:36PM V2 (Director of Resident Care Services/Nursing) stated fall risk assessments are conducted upon admission, every six months, and when falls occur. V2 stated residents care plans would incorporate any changes resulting from fall assessments. V2 stated there were no additional interventions added for R1 after the fall 09/06 because R1 already has floor mats, a floor alarm, a hospital bed, and recently received a new high back wheelchair. V2 stated R1's high back wheelchair allows R1 to lean back a little further as opposed to the standard wheel chair. V2 stated R2's fall interventions included a floor pad and a floor alarm and R2 already has a hospital bed. V2 stated the floor alarms are a thin plastic pad that activate if a resident steps on it which notifies staff that residents are moving. V2 stated floor alarms are usually activated at bedtime. V2 stated during the day R1 and R2 are usually out of their room so the floor alarms are not in use. 10/13/2021 at 2:00PM V2 (Director of Resident Care Services\Nursing) stated there doesn't appear to be a fall risk assessment for R1 or R2	S9999		

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S9999	Continued From page 8 in the assessment binder where it would be located other than their medical chart. Observed there were no fall risk assessments for R1 or R2 located in the assessment binder that V2 searched through. V2 stated a fall risk assessment should be in R1 and R2's medical charts. V2 stated any fall risk interventions would be included in the physical functioning section of a care plan. R1 and R2's most current care plans reviewed 10/13/2021 do not include fall risks or interventions related to behaviors or medical conditions as indicated in their fall reports and staff interviews. R1 and R2's medical charts reviewed 10/13/2021 did not include any fall risk assessments. The facility's fall reduction policy received 10/13/2021 states: "The Director of Resident Care Services at the community will complete an initial assessment of the resident that includes an evaluation of physical functioning." "If there is a concern regarding fall risk, the nurse can assign tasks to monitor every hour, escort resident, refer resident to physical therapy services for further evaluation and intervention." "Identification of risk and prevention is necessary to ensure resident safety." The facility's fall risk assessment form received 10/14/2021 states: "fall risk assessments are conducted upon admission, every six months, and as needed." (B)	S9999		