STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015564	A. BUILDING: _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE GENEVA ROAD	545 BELMONT LANE CAROL STREAM, IL 60188

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S 000	Initial Comments Facility Reported Incident of 10/6/22 /IL152297	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3)A) 330.710c)3)B) 330.710c)3)C) 330.710c)3)F) 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: 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	S9999		

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S9999	Continued From page 1 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. 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. These REQUIREMENTS are not met as evidenced by: Based on observation, interview and record review the facility failed to have a policy to ensure a resident was safely transferred using a mechanical lift device for 1 of 3 residents (R1) reviewed for safe transfers in the sample of 3. This failure resulted in R1 sustaining hemorrhage of the right eye, laceration of R1's right eyelid and laceration of R1's lower lip. Findings include: R1's medical record dated 10/22 show R1 has diagnoses that include diabetes and stroke. R1's plan of care assessment dated 7/21/22 show R1 is alert and able to verbalize needs. R1 needs occasional reminders. R1 needs 2 staff for mechanical lift transfers.	S9999		

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S9999	Continued From page 2	S9999		

R1's Facility Reported Incident (FRI) dated 10/6/22, reported to the state agency on 10/7/22 as initial and final report show, "Nurse arrived and observed resident and [mechanical lift] tilted to the side. She observed bruising to right eye and laceration to his lower lip. 911 was called and paramedics arrived. Paramedics assessed and transferred resident to ER for further evaluation .... Follow up resolution- Resident returned back to the community around 7 PM. Residents sustained laceration to lower lip with 1 suture applied. Right eye has soft tissue contusion and mild right intraorbital hemorrhage."

R1's Emergency Department (ED) notes dated 10/6/22 show "Pt presenting via EMS from nursing home. Per EMS report, was being transferred out of shower on a [mechanical lift] when pt. slid out of lift. Pt hit head on the mechanical lift. Pt with complaints of neck pain, lower back pain and eye pain."

R1's CT (computerized tomography) scan of face result dated 10/6/22 show: head injury trauma fall-Right periorbital soft tissue swelling contusion, mild right intraorbital hemorrhage.

R1's ED discharge instructions dated 10/6/22 show: Reason for visit Fall. Diagnoses: Laceration of lower lip, right eyelid laceration, periorbital contusion of right eye. R1 was discharged back to the facility with order of: Erythromycin 5mg ophthalmic solution 1 application TID and referral to an eye doctor.

R1's Ophthalmology consult dated 10/10/22 show: "eye trauma in right eye, blurred vision, redness, lid swelling, bruising, tearing, flashing lights and eye discharge. Pt had an accident ...mechanical lift fell on him. Diagnosis:

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S9999	Continued From page 3 Subconjuctival hemorrhage of right eye. Plan to see R1 back in 2 weeks." On 10/14/22 at 9:25 AM, R1 was alert and pleasant sitting in his wheelchair. R1's right eye was very red and swollen. The area around R1's right eye was all bruised. R1 said he saw the eye doctor and prescribed eye drops. R1 said the eye doctor told him there's ongoing bleeding under his right eye. R1's mechanical lift device was parked outside R1's apartment. R1 said he fell out of this lift. R1 said right after having a shower, the 2 staff were transferring him from the shower chair to his wheelchair. R1 said as he was suspended in the air and while the lift was being turned, it tipped over to the right side. R1 said he fell on the right side with the lift hitting the right side of his face. R1 then pointed the legs of the lift and R1 stated "the legs were not opened wide enough to balance the lift. That was the reason why it tipped over." On 10/14/22 at 9:56 AM, V7 said she was the Patient Assistant Liaison (PAL) that was controlling the mechanical lift device on 10/6/22. V7 (PAL) said R1 was just given a shower. R1 was being transferred to his wheelchair via mechanical lift. V7 said as she was pulling the mechanical lift device out under the shower chair and was trying to position the lift device to turn towards R1's wheelchair, the mechanical lift suddenly started tipping over to the right side. V7 said she was unable to hold the lift device upright with R1 still suspended in the air. R1 and the mechanical lift ended on the floor. V7 said R1 was injured due to this incident. On 10/14/22 at 10:32 AM, V6 (PAL) said her and V7 (PAL) were both in the shower room to transfer R1. V6 said the sling was under R1 and	S9999		

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S9999	Continued From page 4 the straps were connected to the lift device. V6 said she was behind R1 while V7 was at the opposite side and operated the lift device. V6 said V7 pulled the lift device and started tilting to the side. V6 said she tried to hold the device and R1 upright. Due to R1's weight and the weight of the device, R1 and the device tipped over to the side and R1 ended in her lap. R1 had a cut in his right eye and lower lip. V6 said the lift device legs were not opened wide enough. V6 said the mechanical lift device is more stable when the legs are widened. On 10/14/22 at 11:48 AM, V5 (Registered Nurse-RN) said on 10/6/22 she was paged to go to 3rd floor shower room. V5 (RN) said when she entered the shower room, R1 was sitting on the floor leaning to his right side with the lift sling still attached to R1. The mechanical lift device was also tilted to the side with R1. R1's right eye was bleeding. There was a cut to R1's lower lip. V5 said R1 hit either the mechanical lift or the wheelchair which was parked at his side. V5 said paramedics were called and R1 was sent to the ER via 911. On 10/14/22 at 10:41 AM, V2 (Director of Nursing-DON) said she was at the facility on 10/6/22. V2 (DON) said she heard R1 screamed then she was told that R1 had a fall due to the mechanical lift tipping over. R1's right eye hit the metal sling. R1 had a cut on his lower lip. R1 was sent to the ER. R1 received 1 suture to his lower lip. R1 was referred to an eye MD (Ophthalmologist) for his right eye. V2 said she was the one who did the investigation. V2 said the mechanical lift device legs should have been opened wide enough to provide balance and stability to the mechanical lift.	S9999		

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S9999	Continued From page 5 On 10/14/22 at 12:30 PM, this surveyor and V9 (Head of Therapy) with V10 and V11 (both Physical Therapist Assistants) observed the mechanical lift device. All said they were responsible for training staff on mechanical lift device protocols. All said the legs of the mechanical lift device should remain wide throughout the transfer of the resident, this ensures the lift device does not tip over and it keeps the device stable. V9 said V6 and V7 (both PALs) were reeducated and received training after this incident. The facility policy entitled Safe Resident Transfers (lift devices) dated 2/22/22 did not provide steps on how to safely use the mechanical lift device as confirmed by V2. (B)	S9999		