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 08/31/2023

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 Investigation of August 21, 2023/IL163739	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4240a) Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B) This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from mistreatment and abuse by a facility staff member. This failure had psycho-social impact when R1 became tearful while discussing the incident, and said she experienced increased anxiety and humiliation following mistreatment by a facility staff member. This applies to 1 of 3 residents (R1) reviewed for employee to resident abuse in the sample of 3. The findings include: R1's face sheet, printed April 12, 2023, shows R1 has multiple diagnoses including anemia, anxiety disorder, hypertension, dementia, muscle wasting, thrombocytopenia, and dysphagia.	S9999	Attachment A Statement of Licensure Violations	

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R1's Resident Assessment and Service Plan dated April 28, 2023, shows R1 requires assistance with medications, housekeeping, laundry, bathing, dressing, grooming, changing incontinence products, and toilet use. R1 requires transfer assistance by two staff members and is able to eat independently.

On August 21, 2023, at 6:20 PM, V4 (LPN-Licensed Practical Nurse) documented, "[R1] was noted screaming while transported by PAL (Personal Assistance Liaison). Nurse noted resident's feet caught under wheelchair. Nurse instructed PAL to stop. PAL refused resulting in PAL running over resident's right foot. NOD (Nurse on Duty) took over and escorted resident back to room. Full assessment was done. No acute injuries are noted at this time. Vital signs are stable. No pain noted during assessment ..."

The facility's Initial Narrative Summary Incident Report dated August 21, 2023, shows, "On Monday, August 21, 2023, at approximately 6:20 PM, [V4] (LPN-Licensed Practical Nurse) heard [R1] scream. [V4] observed [V3] (PAL) transporting [R1] in the hallway. [V4] observed [R1's] foot get caught under the wheelchair. [V4] shouted for [V3] to stop, stating "You are hurting her." [V3] replied, "She isn't hurt. She just doesn't want to come and get her medicine."

On August 30, 2023, at 9:45 AM (Executive Director) said, "[R1] went to the dining room to eat dinner that day (August 21, 2023). [V3] (PAL) was pushing the resident back to her unit to get her medication. The resident did not want to wait in line behind other residents to take her medication, and the resident requested to be taken back to her room. [V3] refused to take the

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resident back to her room and continued pushing the resident towards the nurse's medication cart, despite [R1's] objection. [V4] (LPN) told the caregiver to stop pushing the resident when she heard the resident screaming. [V3] had all the necessary training to know this is not how we do things."

On August 30, 2023, at 12:30 PM, R1 was sitting up in a wheelchair in her room. R1 said, "[V3] (PAL) has a rude attitude. I have had problems with her before. I do not like to wait in line for my pills because it gives me anxiety sitting and waiting, so I prefer to wait in my room until the line of residents waiting for medication gets shorter. On August 21, I was sitting in my wheelchair. I asked [V3] (PAL) to push me from the dining room back to my room in my wheelchair. [V3] said, "No, you have to go to the nurse's medication cart!" She started pushing my wheelchair towards the medication room. I did not have the leg rests on my wheelchair, and my legs folded up underneath me and went under my wheelchair, dragging backwards. It was very painful. I started screaming. I did not even know I could make screaming sounds like that. I sounded like an animal. [V4] came around the corner and told [V3] to stop pushing me, but [V3] refused. Then she ran over my foot. I thought it was very rude and unsafe. She could have broken my legs. I had a hip and knee replacement six or seven years ago in my right leg and it is a miracle she didn't break my leg. [V4] (LPN) took me back to my room and checked me over for injuries and assured me she would bring me my pills and I did not have to wait in line for medication. She also said she would keep [V3] away from me. I was afraid she would come back and take care of me again. I have anxiety, and this situation made me more nervous

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and upset. She was treating me like I was four years old. She wanted to be the boss. I told her to stop a number of times and she said no, you are going. It was abusive."

On August 30, 2023, at 2:45 PM, V8 (Human Resource Manager) said she was the manager on duty on the evening of August 21, 2023. "I spoke to the nurse on duty, and she explained what had happened during the incident involving [R1] and [V3] (PAL). The resident was very upset, and she was teary eyed. I kept apologizing to her. She kept saying, 'Why did she do this to me?' I felt the behavior could have been perceived as abusive."

On August 30, 2023, at 3:13 PM, V7 (LPN) said, "I took care of [R1] on August 22 and 23, following the incident on August 21. We usually monitor residents for three days following an incident. On August 23, 2023, the resident presented with a bruise to her right mid-shin. The bruise was long. She verbalized her shin was painful to touch, and I noticed it was slightly swollen. When I saw the bruising and the pain, I thought we should get an X-ray of the leg. The physician ordered an X-ray to her right knee, and her right tibia and fibula to rule out trauma. The X-ray results went to the physician's office."

Facility documentation dated August 24, 2023, shows R1's X-ray results were "negative."

On August 30, 2023, at 11:19 AM, V3 (PAL) said, "I was taking care of [R1] on August 21, 2023. It was around 5:30 PM. We have been told we have to bring the residents from dinner to the medication room. [R1] got upset and she started crying and she said I was hurting her. How am I hurting her? I only pushed her halfway to the

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medication room. I told her she had to get her medication. I told her I am not going to argue with you. She said, 'I don't want you taking me.' She did not want me to take her to the medication cart. The nurse told me I was making the resident upset and hurting her feelings and that I ran over her foot."

On August 30, 2023, at 3:20 PM, V4 (LPN) said, "On August 21, right after dinner, I was passing medications to all of the residents. We have a little medication room, and the residents wait in line outside of the medication room to get their medications. I was passing out medications when all of a sudden, I heard this awful, earth-shattering screaming coming from down the hall. I ran down the hall and I saw [V3] (PAL) pushing [R1] in her wheelchair and both of the resident's legs were caught under the wheelchair, and her legs were being dragged underneath the wheelchair as [V3] pushed the wheelchair. I shouted at [V3] to stop pushing the wheelchair. I said you are hurting her. I must have told her at least 20 times to stop, you are hurting her, and she did not stop. The resident was screaming at a blood-curdling level. When someone is screaming like that, you stop what you are doing. [V3] said the resident wasn't hurt, she was just screaming because she did not want to be brought to the medication room for her medications because she does not like to wait in line. As I was running towards the two of them, I saw the resident move one leg up from being stuck under the wheelchair, and the front wheel of the wheelchair rolled over her right foot. I told [V3] she just ran over the resident's foot. After she ran over the resident's foot, I told [V3] to take the resident back to her room, and [V3] flat out refused to do that. She said if I wanted the resident back in her room, I should take her, that

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the resident is not special or different than anyone else. [V3] had it in her head that the resident didn't want her medications at the nurse's station and wanted medications in her room, and she did not want to accommodate the resident's preference. I explained it was her job to transport residents, and she refused to take [R1] to her room, so I took the resident to her room. The resident told me once her feet weren't being dragged underneath the wheelchair, that she was not in pain anymore. I did a head-to-toe assessment on her and checked her vital signs. Her blood pressure was slightly elevated but everything else was normal. She was very upset. She takes medication, on and off, for anxiety, and she needed the medication following the incident. I took care of her a few days later, and she again said I cannot believe what [V3] did to me and requested some of her anti-anxiety medication. I felt [V3's] behavior that evening had reached another level. I felt her behavior was abusive because she was dragging the resident's feet and pushing that wheelchair while the resident was screaming at a level that did not even sound human. An accident would be something like, "Ouch, my foot hurts" and then realizing you mistakenly rolled over someone's foot, but when someone is screaming to stop and you keep pushing them, you are purposely hurting the individual, and that is abuse."

The facility's Resident Abuse Policy reviewed "07/2005" shows, "Policy: Each resident has the right to be from mistreatment, neglect and misappropriation of property. This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies that include screening, training, prevention, identification, investigation protection

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S9999	Continued From page 6 and reporting to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. All employees are expected to follow this policy, failure to do so will result in immediate termination. Definitions: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caregiver, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Verbal abuse is defined as any use of oral, written, or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal (bodily) punishment. Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services." (B)	S9999		