Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
12			25	20				
IL6015192		B. WING		06/08/2021				
NAMEOF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CHARTE	RSR LVG POPLAR	RECN	ST GOLF RO N ESTATES,					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N (ve)			
PRÉFIX TAG				(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETE			
S 000	Initial Comments		S 000					
	Facility Reported In 06/01/2021/IL13460		8	16	100 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
\$9999	Final Observations		S9999	×				
	Statement of Licens	sure Violations:	2					
	330. 4240a)			N 44				
	Section 330.4240 A	buse and Neglect		<u>s</u>				
5	a) An owner, license agent of a facility sh resident. (Section 2-	ee, administrator, employee or all not abuse or neglect a -107 of the Act)		77 3 20				
**	· ·							
9	This requirement wa	as not met as evidenced by:		2				
9	review, the facility no rests were in place p	on, interview, and record eglected to ensure the leg prior to moving two residents and causing them to fall out	e	te U				
D 48	This applies to 2 of 3 for falls in a sample	3 residents (R1, R2) reviewed of 3.	ts:	4 9				
8	The findings include 1. R1's EMR (Electro that R1 is 93 years of Lumbar Spondylosis Progressive Dement Dysphagia.	onic Medical Record) shows old with diagnoses including with Myelopathy,	"	Attachment A Statement of Licensure Violations				
lipois Depart	ment of Public Health			72	6			

Illinois Department of Public Health

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

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C IL6015192 B. WING 06/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD CHARTER SR LVG POPLAR CREEK **HOFFMAN ESTATES, IL 60194** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 On 6/7/21 at 11:00AM R1 was sitting in her wheelchair in the activity room participating in the activity. R1 sat slouching forward in the chair with her feet on the floor, pushing (rocking) herself back and forth in the wheelchair - using her feet. R1 had a deep purple bruise on her left outer eye and cheek and another bruise on her left upper forehead." R1's Incident Reporting Form dated 6/1/21 states, "Resident was sitting in her wheelchair, being wheeled to the activity room when she put her feet down causing her to fall forward out of the wheelchair. Resident struck her left forehead and cheek and complains of right knee pain." On 6/7/21 at 10:30AM V3 (LPN) stated, "(V6-Activity Aid) was pushing her out of the activity room to the hallway and she put her feet down. She fell out of the chair and struck her left cheek and her right knee on the floor. That was the first time that has happened. I did an assessment and called 911. She went to the hospital and they did CT scans and blood work and everything came back normal. It was just abrasions. It was such a fluke thing. We always tell them to hold their feet up. She usually propels herself with her feet and she doesn't like the foot rests on." On 6/7/21 at 10:42AM V6 stated, "I was taking her (R1) out of the activity room and she put her feet down. She basically flew onto the carpet. I was just pushing her normally. There was a family member coming through the door and there was a lot of traffic in the hallway. She

suddenly put her feet down in the floor. She is always putting her feet down. I think she was sitting on the edge of the chair and as we were going out I think she thought we were going to run into the people and she put her feet down. She

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
740 1041 01 0014 201011			A. BUILDING:		3	2	
IL6015192			B. WING		1	C 06/08/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CHARTER SR LVG POPLAR CREEK 2150 WEST GO HOFFMAN EST							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
\$9999	Continued From pa	ge 2	S9999				
	of, I called the nurse her head. She com	t of the chair that I am aware e and I place my arm under plained of Left forehead pain.					
,	The nurse called 91 place under her hea	1 and I went to get a pillow to ad."		•			
	stated, "If she is bei to put the leg rests of she put her feet down	MM V2 (Director of Nursing) ing escorted- then they need on. (V6) went to move her and wn and she fell out of the					
4 8	just discharged from They propel themse put leg rests on their restraint and really l	e bruising to her face. She was not therapy prior to her fall elves with their feet and if you ir chairs it almost acts like a limits their mobility. During	£				
Ves	On 6/7/21 at 12:55F Director of Rehab S when she came her	PM V5 (Physical Therapist- iervices) stated, "We got her fe from the hospital. We were					
S	discharged from the propels herself in he wheelchair that fits I discussing this with fall but I am not awa	e muscle strength. She was erapy on 5/29/21. She usually er chair. She needs a her better and I have been her family. I was aware of her are of the details. No one is a wheelchair without leg			E		
<u>m</u>	Resident will be free for this goal states,	ated 3/3/21 states, " Goal: e from falls." The intervention "Staff to assist resident and ion to minimize risk of falling.		-3 *.			
	has diagnoses inclu	that R2 is 95 years old and ding (H/O) Falls, Cognitive porosis and Osteoarthritis.					
	R2's Incident Repor	ting Form dated 6/3/21 states,				-	

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
IL6015192		B. WING			C 06/08/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
	consider the second of the work of the wor	in wheelchair to bathroom, he ground causing her to fall wheelchair and onto the floor." AM V3 (LPN) stated, "The RA was pushing her from her proom- they were in the rea in the room). She put her ut of her chair onto her right in tear on her right index finger. Oderate amount of blood. She to me as she normally does they took her to the hospital. I con her cognitive status not was admitted for sepsis and he has leg rests on her chair enthem on for that transport." AV4 (RA) stated, "I was athroom and she put her feet She is usually pretty compliant he knows me. She has leg ut I did not have them on her. To the bathroom. She has ore. I don't know if she was that morning or what." AM V2 (Director of Nursing) thy has a transport chair and I is legs rests for her chair. To work with her to get all. It depends on what the lily when they have been gone poing to rehab for a little will come back here. I know to the bathroom. She has legs and maybe she was The admission to the hospital	\$9999				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health
STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPI	LIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION	IUMBER.	A. BUILDING:			COMPLETED	
IL6015192		G	B. WING		06	C 06/08/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
CHARTE	2150 WEST GOLE ROAD							
CHARTE	CHARTER SR LVG POPLAR CREEK HOFFMAN ESTATES, IL 60194							
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	(X5) COMPLETE DATE		
\$9999	Continued From page 4			S9999			0	
8	On 6/7/21 at 12:55PM V5 (Physical Therapist- Director of Rehab Services) stated, "She has a transport chair and it has leg rests on it. The leg rests should be on with any movement of the chair."			3(4			0	
	R2's Service Plan of Resident will be fre for this goal states, implement interven	e from falls." The ir "Staff to assist resi	itervention ident and					
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