

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 6016430	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/22/2024
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NAME OF PROVIDER OR SUPPLIER PARK PLACE CHRISTIAN COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 EUCLID AVENUE ELMHURST, IL 60126
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S 000	Initial Comments	S 000		
S9999	<p>Complaint Investigation 2477517/IL178174</p> <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210c) 300.1210d)6)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p>	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE

09/27/24

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S9999	<p>Continued From page 1</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to safely transfer a resident during toileting when a gait belt was not used, and required assistance was not provided. This failure resulted in R1 sustaining an acute comminuted fracture of the left femur due to a fall incident occurred during direct care. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed R1, a 92-year -old with diagnoses includes dementia, depression, osteopenia, osteoarthritis, stroke, history of breast cancer and pulmonary embolism. R1's surgical history includes right</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>knee replacement. R1 was Covid positive on August 4,2024. R1 was originally admitted to the MMC (Memory Care Center) in the facility on October 11, 2019. R1 was transferred to the skilled section in the facility on September 3, 2024. due to declining condition, multiple falls, and weakness.</p> <p>The incident report log showed R1 had 2 falls for 2 weeks period. The incident report dated September 7, 2024 at 4:40 P.M., showed R1 ended up on the bathroom floor when R1 was getting off the toilet and slid down. The incident report dated September 16, 2024 at 2:00 P.M., showed during toilet assistance by V3 (CNA/Certified Nurse Assistant), R1's was assisted to the floor because R1's knees buckled up during the toilet/transfer assistance. This incident showed R1 had complained of pain to the left lower extremity after the fall. An x-ray was done on same day, with result of "acute comminuted impacted supracondylar fracture of the left femur."</p> <p>The progress notes dated 9/16/2024 showed R1 was sent out to the hospital and was admitted due to fracture.</p> <p>On September 20,2024 at 12:14 P.M., V2 (Director of Nursing) said R1's fall on September 7, 2024 was because R1 was left alone in the bathroom as the CNA provided privacy to R1. V2 added R1's fall on September 16,2024 happened when V3 assisted R1 to the toilet, then R1 got weak, and legs buckled up. V2 said V3 assisted R1 to the floor. V2 added R1 then complained of left knee pain after the fall and x-ray was done. V2 said x-ray showed an acute fracture of R1's</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>left femur.</p> <p>On September 20/2024 at 11:15 A.M., V4 (Registered Nurse) said he was the assigned nurse when R1 had a fall on September 16, 2024. V4 said he had also taken care of R1 when R1 was at the MMC. V4 said R1 was transferred to the skilled unit on September 3, 2024 due to R1's decline in level of functioning, was weak due to post Covid infection (August 4,2024). V4 said R1 had been falling at the MMC almost "every other day" and was then moved to skilled unit for closer supervision and assistance. V4 said when he arrived at the scene when R1 fell on September 16,2024, R1's knees were bent and R1's feet were caught between the toilet base and the legs of the toilet riser. R1's upper extremity was in upright position and lower extremity in sitting position on the floor, knees bent, and upper body slightly leaned towards the right side. V4 said R1 was assisted back to bed using a total lift mechanical transfer device. V4 said R1 had complained of pain to the left upper knee when touched. V4 said due to R1's "declining condition, 2-person assist is required when providing care to ensure safety."</p> <p>On September 20,2024 at 10:38 A.M., V3 said she had assisted R1 to the bathroom on September 16,2024 around 2:00 P.M. V3 said she started assisting R1 in the bathroom from sitting position from the wheelchair. (R1) grabbed the grab bars to pull self-up to standing position. (R1) started to pivot transfer on her own while (V3) was pulling down R1's pants since (R1) had a large bowel movement. During this time, (R1's) legs buckled up, and there was no way to avoid falling to the floor so (V3) eased down (R1) to the</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>floor. (R1's) feet caught in between the toilet base and toilet riser. (R1) complained of left upper leg pain. V3 called (V4) at once and they transferred (R1) to her bed via total lift device. V3 said she did not use gait belt to R1 during toilet transfer. V3 said while she was pulling down R1's pants, R1 had no stability and no assistance since V3 was pulling down R1's pants.</p> <p>On September 20,2024 at 12:44 P.M., V8 (RN/MDS/Care Plan) said R1 requires total assistance for lower body dressing, totally dependent from staff for toilet use, and required substantial assistance for transfer.</p> <p>On September 20,2024 at 2:50 P.M., V5 (CNA) said R1's functional level varies, sometimes R1 resist care and assistance of 2 person was required for safety.</p> <p>On September 20,2024 at 1:10 P.M., V9 (Occupational Therapist) said she had provided occupational treatment to R1 on September 6, 9, 10 and 13, 2024. V9 said R1's functional level varies and is unpredictable. V9 said at times R1 requires 75 % to 100 %, was totally dependent from staff then there were times R1 requires 25 % assistance. V9 added if a task is given one at a time to R1, then 1 person assist is okay since the assistance was focus on a single task, but if 2 or more tasks were provided at the same time, then 2 persons plus assistance was required for R1 to be safe during provision of care. V9 said when R1 was doing pivot transfer and V3 was pulling down R1's pants, V3 was doing assistance for undressing, and a transfer assistance task was not provided. V9 said, "One</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>task should be provided at a time with 1-person assist, and with 2 tasks being provided at same time, 2 persons assists were required. Also do not undress during pivot transfer."</p> <p>On September 22,2024 at 12:15 P.M., V2 said transfer belt/gait belt is a must to use when transferring a resident. V2 said 2 person assistance was required when 2 tasks of care is being provided at the same time.</p> <p>On September 20,2024 at 2:27 P.M., V10 (R1's Primary Physician) said she was notified on September 16, 2024 when R1 sustained a fall, landed on knees, and R1's knees were swollen. V10 said R1 sustained acute fracture of the left upper leg (femur) due to the fall incident occurred September 16.2024.</p> <p>The MDS (Minimum Data Set) dated September 9, 2024 showed R1's cognition was moderately impaired with BIMS (Brief Interview Mental Status) score of 8/15. The MDS also showed R1's functional level assessment as follows: -functional limitation in range of motion on both sides for both upper and lower extremities -dependent for toilet hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding, or having a bowel movement) -dependent for lower dressing (ability to dress/undress below the waist) -dependent from sit to stand (ability to come from to a standing position from sitting position in a chair/wheelchair) -dependent for toilet transfer (the ability to get on and off a toilet or commode)</p> <p>The MDS code were as follows:</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>-"substantial/maximal assistance: Helper dose "MORE THAN HALF the effort. Helper holds or lifts trunk, or limbs and provides more than half the effort.</p> <p>-dependent: Helper does ALL the effort. Resident does none of the effort to comply the activity. The assistance of 2 or more helpers is required for the resident to complete the activity."</p> <p>The care plan dated September 3,2024 showed R1 requires total assistance for lower body dressing, totally dependent from staff for toilet use, and required substantial assistance for transfer.</p> <p>The fall risk assessment dated September 7,2024 showed R1 was a high risk for fall.</p> <p>The progress notes dated September 20, 2024 showed R1 returned to the facility at 6:30 P.M. R1 was also placed on hospice care. On September 21, 2024 at 10:30 A.M. R1 was observed lying in her bed. R1 was lethargic and barely responsive. R1's left lower extremity was moderately swollen.</p> <p>The facility policy for "Lifts and Safe Client Movement Program" with review date of September 2024, showed: "POLICY:is committed to providing safe care maximizes clients' quality of life while maintaining a safe work environment for employees. The Safe Client Movement Program includes client movement equipment, employee training, client plan of care and a "culture of safety" approach to safety in the work environment.</p> <p>6. When a client is being assisted with a transfer</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>and another ADL task is needed a client also needs assistance with such as dressing/undressing"</p> <p>The facility policy for "Gait Transfer Belt" with review date of May 2024, showed: IMPORTANT POINTS: 2. Gait belt use is mandatory with all residents who need assistance in ambulation and /or transfer."</p> <p>(A)</p>	S9999		