| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **146155** | A. BUILDING _____ B. WING _____ | **03/12/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PARK PLACE CHRISTIAN COMMUNITY** | **1150 EUCLID AVENUE ELMHURST, IL 60126** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on interview and record review the facility failed to use a gait belt during transfer of a resident per facility's policy. This applies to 1 of 5 residents (R17) reviewed for falls in the sample of 12. The findings include: On 03/10/20 at 12:39 PM, R17 was observed in her room sitting in wheel chair with V5 (daughter). R17 stated that she had a fall last week. V5 stated that V4 CNA (certified nursing assistant) was transferring the resident from the recliner to the wheel chair with out using the gait belt. Nurses notes dated 03/05/2020 at 1: 30 PM showed that V4 notified V3 (nurse) that R17 was on the floor after attempting to transfer R17. Complained of right ankle pain and right hip pain post incident. V6 (R17's daughter in law) was at bedside when incident happened. Per V6's statement R17 was supported by the assigned CNA with one hand under the patient's armpit during the transfer. No gait belt was used nor was the CNA standing in front of her. Patient was unable to pivot and was sat back down again to the recliner. Assigned CNA tried again to transfer R17 but R17 barely made it to the wheelchair and slid off the seat falling on her right knee which bent underneath her. R17's physician was notified about the incident and ordered x-rays to bilateral hip, right knee and ankle. Facility's incident report showed that R17 was lowered to the ground by CNA during transfer, no gait belt in place at the time of incident, and R17 was supported by V4 with only one hand under the resident's armpit while not standing in front of R17. On 03/11/2020 at 12:00 PM, V4 stated she was suppose to use a gait belt when she transferred R17. V4 stated that she forgot her gait belt at home that day and the facility's policy is to use gait belt to all residents during transfer. On 03/11/2020 at 1:30 PM, V3 (nurse) stated she was present after R17 fell and assessed R17 for injuries. V3 stated V4 did not use a gait belt when attempting to transfer R17. On 03/11/2020 at 2:30 PM, V1 (administrator) stated that the CNA definitely should have used the gait belt during the transfer that resulted in R17's fall. MDS (minimum data set ) dated 02/23/2020 showed that R17 requiring extensive assistance with two person physical assist in bed mobility, transfer and toileting. The care plan showed that R17 is at risk for fall secondary to right knee revision, weakness and pain on right lower extremities. The facility's Lifts and Safe Client Movement Program Policy and Procedure with revised date 05/19, shows, Policy: The facility is committed to providing safe care that maximizes client's quality of life while maintaining a safe work environment for employees. The safe client movement program includes client movement equipment, employees training, client plan of care and a culture of safety approach in the work environment. Employee responsibilities: It is the responsibility of the employee to take reasonable care of their own health and safety as well as that of their clients and co-worker during client movement activities. Employees are expected to follow this policy; non compliance will indicate the need for re-training and/or disciplinary action. Procedure: Gait belts will be used unless medically contraindicated. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.