

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/04/2025
NAME OF PROVIDER OR SUPPLIER PARKVIEW HOME - FREEPORT		STREET ADDRESS, CITY, STATE, ZIP CODE 1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032		
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S 000	Initial Comments Facility Reported Incident of 1/20/25/IL184882	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3)A)B)F)H) 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 resident populations served by the facility and the physical environment in which the resident handling and movement occurs.	S9999		

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

TITLE

(X6) DATE

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S9999	Continued From page 1 B) Education and training of nurses and other direct resident care providers in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling and on safe lifting policies and techniques and current lifting equipment. 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. H) Fostering and maintaining resident safety, dignity, self-determination, and choice. (Section 3-206.05 of the Act). This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to safely transport a resident in a wheelchair for 1 of 3 residents (R1) reviewed for safety in the sample of 3. This failure resulted in R1's toe getting caught in the wheel of the wheelchair, causing R1 to fall to the floor, sustaining a fracture to her right great toe. The findings include: On 2/4/25 at 12:04 PM, R1 was seated at a dining room table with the foot pedals of her wheelchair opened to the sides. R1 was wearing regular, white socks. R1 did not have on any footwear. R1's feet did not reach the ground and were hovering 2-3 inches from the floor. At 1:10 PM, R1 was in her room. R1 was sitting on the seat of her wheeled walker, at her desk. R1 was wearing white socks and had to wiggle her bottom to the	S9999		

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S9999	Continued From page 2 edge of the seat to touch her feet on the floor. R1 used her feet to push her wheeled walker back, so she could face the surveyor. R1 said she had fallen at the facility and broke her right big toe. R1 said she had just returned from her doctor's appointment and V3 (Social Services/Transport) was pushing her back to her room, in a wheelchair. R1 said she had to use the wheelchair because her room as a long way from the main entrance. R1 said she was going to the doctor because she was already having trouble with her left foot. R1 said they went around the corner and the tip of her right slipper got stuck in the wheelchair wheel. R1 stated, "I flipped right out of the chair. It hurt pretty bad. I had a blister on my toe (where it was caught in the wheelchair) and then it got pretty bruised and swollen. They did an X-ray and I broke my big toe (R1 pointed to her right great toe) from it. The doctor ordered for me to be in a boot, even when I was sleeping. I didn't like it because it was causing my foot to swell more, so I don't wear it. I told the doctor, when I saw him last. They said it seems to be healing up okay. It still hurts if I put weight near the my big toe or the front of the foot. I try to put my weight in the heel, but then that bothers my knees too. It's awful getting old. I've also been dealing with my eyes going bad. It's like I'm looking from a glass bowl. I can't read. I can see there is something there, but not all the detail." R1's Facesheet dated 2/4/25 showed diagnoses to include, but not limited to: major depressive disorder, diabetes, hypertensive retinopathy (visual difficulty), and lupus. R1's BIMS (Brief Interview for Mental Status) dated 11/4/24 showed R1 was cognitively intact. R1's Fall Risk Assessment dated 11/4/24 showed	S9999		

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S9999	Continued From page 3 she was had a "High Risk for Falling." R1's Service Plan initiated 11/4/24 showed, "Resident has a history of falls prior to admission to Shelter Care. Witnessed fall on 1/20/25... Interventions: ...Encourage resident to wear slippers or shoes with nonskid soles when walking. Staff will transport [R1] longer distances using a wheelchair with foot pedals (initiated 1/21/25 - after R1's fall). R1's Fall Initial Note dated 1/20/24 at 12:36 PM showed, "Received a call from receptionist. Resident on floor lying on left side. Transporter was wheeling resident in wheelchair and when turning a corner the resident was leaning forward and fell out of the wheelchair. Resident states she lightly bumped her head. No evidence of head injury...Resident said her foot got caught in the wheelchair and she slid to the floor..." R1's Nurses Note dated 1/21/25 at 9:10 AM showed, "0700 Noted on right foot, great toe and second toe purplish bruising on the front and back. A blister noted on the great toe measuring 4 cm x 2 cm (red). Resident states she has "some discomfort" when wiggling right toes. Instructed resident not to ambulate and the staff will assist resident. 0815 Orders per [Nurse Practitioner] for X-ray right foot 2 view..." R1's Right Foot X-ray Report dated 1/21/25 showed, "Acute 1st proximal phalanx (great toe) fracture by 2 views." On 2/4/25 at 9:23 AM, V3 (Social Services/Transport) said she takes R1 to appointments 1-2 times per month. V3 said she transferred R1 to the main entrance with the wheelchair because it is a long walk from R1's	S9999		

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S9999	Continued From page 4 room and she had a sore on her foot. V3 said on 1/20/25 they had returned from R1's doctor's appointment. V3 said she assisted R1 into the wheelchair and pushed her into the building. V3 said she did not place the foot pedals on R1's wheelchair. V3 stated, "I don't know why I didn't because I usually do for a longer distance. You can ask the CNAs, I'm kind of the foot pedal police. I pushed her around the first corner and we were just talking, then when I went around the second corner, she went forward and kind of tucked and rolled. I had gloves on and tried to catch her, but the gloves slipped on [R1's] winter coat. I tried. I called for help and [V4 - Receptionist] called the nurse for me. The nurse came to help and [R1] said she was OK. The next day I saw the nurse and she said [R1's] toe was bruised and might be broken. I didn't feel a bump, like her foot got caught. It looked like she was repositioning in the wheelchair and she fell forward. She (R1) proceeded to tell me it wasn't my fault, but I did "dump her out of the wheelchair." V3 said R1 doesn't like shoes and prefers to wear slippers mostly. V3 said R1 is alert and oriented and able to make her needs known. On 2/4/25 at 9:42 AM, V4 (Receptionist) said she was working at the main entrance on 1/20/25. V4 said she saw R1 and V3 (Social Services/Transport) return from an appointment. V4 said V3 was pushing R1's wheelchair, but she couldn't recall if the foot pedals were on the wheelchair. V4 said she did not witness the fall, but heard V3 yell for help and she called the nurse to assist. V4 said when she looked checked, R1 was lying on the floor in front of the wheelchair. V4 said she remembers seeing V5 (LPN - Licensed Practical Nurse) come down, but she didn't stay because there was nothing she	S9999		

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S9999	Continued From page 5 could do to help. On 2/4/25 at 10:25 AM, V5 (LPN) said she was working on 1/20/25 and she received a call that R1 had fallen out of the wheelchair. V5 said V3 was bringing R1 back from a podiatrist (foot doctor) appointment. V5 said V6 (CNA) and V7 (LPN) also came to help with R1. V5 said by the time she got to R1, she was sitting on her butt, on the floor, in front of her wheelchair. V5 said R1 told her that her foot got caught in the wheel and she fell. V5 said she performed an assessment and there were no signs of immediate injury. V5 said they assisted R1 off the floor, but the bruising didn't show up until the next morning. V5 said she went into R1's room to provide a treatment to her foot and noticed the purple bruise to her right great toe and 2nd toe. V5 said R1 reported that it hurt to move her toes. V5 said she notified the Nurse Practitioner and she ordered X-rays of R1's foot. V5 said the X-ray report showed R1's great toe was fractured (broken) and she was supposed to wear a surgical boot. V5 said R1's wheelchair did not have the foot pedals on. V5 said the foot pedals should have been on R1's wheelchair to prevent her foot getting caught. V5 said it's for safety. On 2/4/25 at 2:22 PM, V7 (LPN) said she was working on the other unit and received a call from V4 (Receptionist). V7 said she asked V6 (CNA) to come with her and went to help. V7 said R1's nurse (V5) had already arrived when she got there. V7 said R1 was sitting on her butt, on the floor. V7 said the foot pedals were not on R1's wheelchair. V7 said R1 said her slipper got caught in the wheel. On 2/4/25 at 11:20 AM, V2 (DON - Director of Nursing) said she was working the day R1 fell	S9999		

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S9999	Continued From page 6 (1/20/25). V2 said she was notified of the fall that day, but she did not witness the fall or assess the resident. V2 said R1 didn't complain of pain until the next day and an X-ray was ordered. V2 said R1's X-ray showed she broke her right great toe. V2 said if a resident is being pushed in a wheelchair a longer distance, then the staff should always use the foot pedals. V2 said it's unlikely a resident would be able to safely hold up their feet for a long distance. V2 said the staff should place the foot pedals on the wheelchair and ensure the residents remains in the proper position throughout the transport. V2 said this is done for resident safety. V2 said the facility does not have a policy regarding proper wheelchair use and transfer. A policy and procedure for wheelchair transfers was requested and not received. (B)	S9999		