

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/30/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW HOME - FREEPORT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032</b>		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Facility Reported Incident of 5/16/2025/IL192650	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.1210b)5) 300.1210c) 300.1210d)6)  Section 300.1210 General Requirements for Nursing and Personal Care  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. Restorative measures shall include, at a minimum, the following procedures:  5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning  c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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>THIS REQUIREMENT WAS NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview and record review, the facility failed to safely transfer a resident according to the resident's care plan for 1 of 3 residents (R1) reviewed for safety in the sample of 3.</p> <p>The findings include:</p> <p>R1's Admission Record, provided by the facility on 5/30/2025 showed she had diagnoses including, but not limited to, repeated falls, localized edema, pain in left lower leg, neuromuscular dysfunction of bladder, fracture of left pubis, cataract, bilateral age-related macular degeneration, dementia, pain in right hip, cervical disc disorder with radiculopathy, essential hypertension, anxiety disorder, presence of aortocoronary bypass graft, and peripheral vascular disease. R1's care plan, with a revision date of 5/20/2025, showed two staff, a gait belt and a walker and/or a wheelchair will be used with resident for transfers. The care plan showed on 12/17/2024 one-to-two staff, a gait belt and a walker and/or wheelchair will be used with resident for transfers. Order requested for a (mechanical sling lift) as needed and was received on 9/26/2024. The care plan showed R1 was at risk for falls due to mobility issues, she</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>does not walk and had a history of falls. R1's Brief Interview For Mental Status Evaluation dated 3/12/2025 showed R1 had short-term and long-term memory problems. R1's Progress Note dated 5/16/2025 showed R1 was in the recliner. Two Certified Nursing Assistants (CNAs) went to stand resident up without a gait belt. The resident and the two CNAs went to the floor. The resident was on her right side. Resident legs were normal looking, no rotation or shortening noted. Wound to the right elbow (skin tear 3 centimeters (cm) well approximated, cleansed and steri stripped, adapt and (foam) dressing applied. Resident reports "Get me up." Was noted to have a hematoma bump to the right side of the forehead. Was gotten up per mechanical lift. The note showed the doctor on-call was notified and the resident was sent out at 9:10 PM per ambulance. R1's Order Summary Report, provided by the facility on 5/30/2025, showed an order for Clopidogrel (a platelet inhibitor-may increase the chance of serious bleeding in some people) 75 milligrams daily.</p> <p>On 5/30/2025 at 9:43 AM, R1 was observed in the sitting area by the nurse's station in a wheelchair. R1 had a hematoma on the right side of her forehead that was dark to medium purple in color, and a yellow and light purple faded bruise to her right cheek bone. R1 agreed to talk with this surveyor in her room. R1 was asked how she got the bump on her head. R1 said she did not know what happened that caused the bump on her head. R1 said she does not think she had a fall. R1 had a skin tear on her right elbow that was secured with three steri-strips. R1 was asked how she got the wound to her right arm. R1 said she did not know what was going on. R1 was confused and not interviewable.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>On 5/30/2025 at 9:56 AM, V6 and V7 (CNAs) put a gait belt on R1 and transferred her by stand-pivot transfer from the wheelchair to the recliner. R1 did not assist with the stand pivot transfer.</p> <p>On 5/30/2025 at 10:50 AM, V2 (Director of Nursing-DON) said the two CNAs that were transferring R1 when she fell got written up. V2 identified V4 and V5 as the CNAs transferring R1 when she fell on 5/16/2025.</p> <p>On 5/30/2025 at 11:05 AM, V4 (CNA) said We forgot a gait belt and went to transfer (R1). It felt like her legs gave out and we could not support all that weight. V4 said R1 is normally a two-assist with a gait belt, stand and pivot transfer. V4 said the nurse was right there when it happened. We were in the sitting area by the nurse's desk. We were transferring her from the recliner to her wheelchair to take her to bed. We were trying to pivot-transfer her. Our arms were under her arms. I think her legs gave out, we just could not hold her up and we all went over and fell on the floor. V4 said it is important to make sure the gait belt is on the resident for extra support.</p> <p>On 5/30/2025 at 11:24 AM, V5 (CNA) said "We were getting her (R1) up. I was on the right side and (V4) was on the left side of (R1). I felt the weight go towards (V4) and we all went to the left. V5 said R1 did not have a gait belt on. "We forgot. She is supposed to have one on. We messed up."</p> <p>On 5/30/2025 at 12:11 PM, V3 (Licensed Practical Nurse-LPN) said she was the nurse on duty when R1 had the fall on 5/16/2025. V3 said she was in the area by the nurse's desk, focused</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>on a different resident with a feeding tube. V3 said V4 and V5 went to transfer R1 to her wheelchair and they all three fell to the floor. V3 said V4 and V5 did not use a gait belt when they went to transfer R1. V3 said she believes R1 is a two-assist with a gait belt for transfers. V3 said she went over to assess R1. She denied pain at the time. She had a skin tear on her elbow that was bleeding. We got her up and took her to her room and put her in bed. V3 said R1 did not have a bump on her head when she first assessed her in the sitting area, but when they got her in bed, she had a bump on her forehead. V3 said she notified the doctor and sent R1 out to a local hospital. V3 said V4 and V5 should have used a gait belt when transferring R1.</p> <p>R1's 5/17/2025 Patient Visit Information from the local hospital emergency department showed R1 had a scalp hematoma and a urinary tract infection.</p> <p>The facility's policy and procedure titled Use of a Gait/Transfer Belt, with a revision date of 1/25/2025, showed an assistive and safety device utilized in transferring or ambulating residents who need assistance. Utilized in assisting weight-bearing of a resident, who is weak during transfers and ambulation. A safety device that is used to avoid injury to the resident or caregiver and promote a resident's feeling of security. Gait/transfer belts are to be used with all residents needing assistance to transfer or ambulate, this includes residents that are stand-by-assist unless otherwise ordered by physician or physical therapist.</p> <p>The facility's undated policy and procedure title Two Person Transfer showed "2. Tell the resident what you are going to do. 3. Ensure the braked</p>	S9999		

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S9999	Continued From page 5  are locked on bed, wheelchair, etc., 4. Ensure leg rests etc., are out of the way. 5. Apply the gait belt snugly. 6. Have the resident scoot forward, feet flat on the floor. 7. Place your arm under their arm and your hand down into the gait belt so you can assist in lifting them. 8. Block feet and knees with your feet and knees. 9 Instruct resident to lean forward (nose over toes) on the count of three to push up with their legs and on their arms to assist in standing. 10. After resident comes to a stand, either pivot-transfer or use a walker to ambulate resident..."  (B)	S9999			