STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510274	A. BUILDING: _____ B. WING _____	C 11/27/2024

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PORTER PLACE	17833 HARLEM AVE TINLEY PARK, IL 60477

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A 000	Initial Comment Complaint Complaint #IL181402 --unsubstantiated FRI: #IL179578 --295.4010 FRI: #IL175513 --295.4010 FRI: #IL174256 --295.4010 --295.6010 FRI: #IL173985 --295.4010	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's	A4010		

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A4010	Continued From page 1	A4010		

condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)

e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

This requirement is not met as evidenced by:

Based on observation, record review and interviews the facility failed to develop and implement individualized goals and interventions to address resident falls in an effort to prevent continued falls. These failures created a substantial probability of severe harm to 4 of 6 residents sampled (R1, R2, R3 and R4) experiencing multiple falls and in one resident exhibiting aggressive behavior.

Findings include:

1). R1's closed record was reviewed and documented the resident had diagnoses including Dementia and Depression and showed R1 had multiple falls (10 falls)from 3/27/24 through 10/5/24. Incident Reports also document the resident had multiple falls. R1's record also contained entries regarding the resident's aggressive behavior during personal care.

Review of R1's service plan (SP) showed the facility failed to revise the SP and develop and implement individualized goals and interventions to address the multiple falls and aggressive behavior when it became apparent those interventions in place at the time of R1'd falls and

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A4010	Continued From page 2	A4010		

behavior were ineffective.

2). R2 was admitted with a diagnosis of Dementia. Review of Incident Reports document the resident had 16 falls between 12/23/23 through 10/25/24. Progress Notes 12/23/23 document R2 falling sustaining a hematoma on the left forehead and transfer to the hospital where he was admitted. Note of 3/5/24 document the resident had orbital bruising of left eye and bruising left cheek and chin due to a fall on 3/4/24.

On 1/22/24 R2 fell again this time sustaining a large hematoma on the left side of forehead, a small laceration and scant bleeding, dizziness and nausea. R1 was documented as alert to person (X1) with intermittent confusion. R1 was transferred to the hospital and admitted with a diagnosis of left side hematoma and brain bleed.

Review of R2's SP shows it wasn't revised and new individualized goals and interventions implemented to address R2's multiple falls and injuries when it was obvious that the fall interventions in place were ineffective.

3). R4 was admitted with diagnoses including Dementia and Parkinson's. Review of the resident's closed record and incident reports show the resident fell 14 times between 1/5/24 through 6/3/24. The resident was assessed as a fall risk on 6/30/24 (After her 6/3/24 fall) and had a cognitive assessment of 12 indicating cognitive impairment.

Progress Notes document R4's noncompliance with staying in her wheelchair and on 6/3/24 documents on R4 stood fell, sustained an abrasion to her left face and was transferred to

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A4010	Continued From page 3	A4010		

the hospital and admitted, but doesn't document the reason for her admission. R4 didn't return to the facility. Incident Report of 6/3/24 mentioned the resident fell, hit her head and sustained an abrasion to the left side of her head and was transferred to the hospital.

Review of R4's SP showed it wasn't revised and new goals and individualized interventions developed and implemented to address the resident's multiple falls and continued attempts to stand and transfer on her own when it became apparent those interventions in place weren't effective.

4). R3 has diagnoses that includes Vascular Dementia. R3 ' s cognitive assessment assessed the resident as " 10 " indicating cognitive decline.
Review of Incident Reports and Progress notes documented R3 fell 3 times 2/11/24, 2/12/24 and 7/7/24. Her fall risk assessment documented R3 as at risk for falls.

R3 ' s Progress note of 5/20/24 documented staff observing the resident had a raised bump on the right forehead which was black and blue and the right eye was red. R3 couldn ' t say how the injuries occurred. R3 was transferred to the hospital and admitted with a diagnosis of Anemia.

Review of R3 ' s service plan showed it hasn ' t been revised with new goals and individualized interventions developed and implemented in an effort to prevent additional falls when it became apparent the interventions in place were not effective.

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A6010	Continued From page 4	A6010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

This Regulation is not met as evidenced by:
TYPE 3 VIOLATION
Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting

a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:

1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.

2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

b) A written report of the investigation

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A6010	Continued From page 5 conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future.	A6010		

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A6010	Continued From page 6 c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed This requirement is not met as evidenced by: Based on record review and interview the facility failed to investigate unexplained bruising and injury for one of 6 sampled residents (R3) reviewed for injury. Findings include: R3 ' s Progress note of 5/20/24 documented staff observing the resident had a raised bump on the right forehead which was black and blue and the right eye was red. R3 couldn ' t say how the injuries occurred. R3 was transferred to the hospital and admitted with a diagnosis of Anemia. When asked if the facility had investigated the cause of the injuries on 5/20/24, E1 (Executive Director) stated she was unsure and was unable to provide evidence of a complete written investigation into the cause of R3 ' s injuries on 5/20/24. R3 was alert but unable to answer this surveyor ' s questions regarding the injury.	A6010		

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A6010	Continued From page 7 When asked if the facility had investigated the cause of the injuries on 5/20/24 E1 (Executive Director) stated she was unsure and was unable to provide evidence of a complete written investigation into the cause of R3 ' s injuries on 5/20/24.	A6010		