STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510483	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE POINT PLACE	5701 W 101ST OAK LAWN, IL 60453

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A 000	Initial Comment Complaint Investigation Survey: IL179945/2498781-Not Substantiated IL180105/2498900- Not Substantiated Facility Reported Incident: IL180065- Substantiated IL183003-Substantiated IL183159-Substantiated IL183651- Substantiated	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 3 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. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care.	A4010		

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A4010	Continued From page 1 c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's	A4010		

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A4010	Continued From page 2 ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure fall interventions are updated and individualized for one (R5) of three residents reviewed for fall. Findings include: An onsite visit was conducted on 1/14/25 and 1/15/25. Per R5's face sheet, R5 is 79 years old. R5's diagnoses include but not limited to Vascular Dementia. R5 moved to the establishment on 12/7/24. On 1/15/24 at 10:32am, R5 was observed in his apartment. Stated no issue with care. R5 was lying down on a narrow bed. There was no fall mat observed on the floor. R5 is independent with mobility without any device. R5's fall incident report indicated that on 12/27/24 at 4:00pm, slipped out of bed. R5's notes dated 12/28/24 indicated R5 was sent to the hospital and diagnosed with Closed Head Injury. R5's Service plan dated 12/7/25 fall interventions	A4010		

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A4010	Continued From page 3	A4010		

were; "report to the nurse any observed or reported falls, change in gait/ balance, change in toileting ability, changes in cognition, and any observed safety hazards in the resident's unit (cluttered walkways, poor lighting, adaptive equipment in poor repair)"

This service plan was updated on 12/31/24 to include this intervention: "Caregiver will monitor resident sleeping position to avoid fall resident just be in the middle of the bed."

On 1/15/25 at 11:57am, E2 (Clinical Services Director) said R5's family was informed and will change the bed. Up to the time of visit, the bed has not been changed.

Per R5's fall incidents reports, R5 had additional falls:
12/31/24 9:30pm: stated he slipped out of bed and he did not know how.
1/10/25 3:30am: resident said he rolled out of bed.

Service plan update dated 1/10/25: "Assist resident with bed positioning to ensure resident is positioned in middle of bed. Care giver will monitor frequently and make sure body alignment is correct to avoid falls."
The intervention was unchanged, just rephrased.

On 1/16/25 at 9:42am, E2 was asked what intervention in place while waiting for the change of bed, "We have to keep him in the common area while awake. And this should be in the service plan."

This intervention was not reflected on the service plan. On two out of three fall incidents, R5 fell out bed during sleeping hours. There are no other

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A4010	Continued From page 4 interventions while waiting for the family to change R5's bed aside from what has been stated.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to follow safety measure to prevent elopement, resulting to one (R5) resident exiting a secured area. Findings include:	A4060		

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A4060	Continued From page 5	A4060		

Per R5's face sheet, R5 is 79 years old. R5's diagnoses include but not limited to Vascular Dementia. R5 moved to the establishment on 12/7/24.

On 1/15/24 at 10:32am, R5 was observed in his apartment.

R5's Service plan indicate R5 is independent with mobility, no mobility aide required.

Incident report dated 12/15/24 at 3:30pm, indicated R5 walked behind a family and exited with them.

On 1/14/25 at 3:26pm, E4 (Receptionist) said "There was a visitor coming out and he (R5) was walking by and he walked out while the visitor was coming out." The door E4 was referring to, is a lock door that leads to the lobby. This door is monitored by a camera. The receptionist on duty can view the feed from the reception desk. The Receptionist open the door for visitors or individuals who do not have access to unlock the door. E4 said, R5 approached the main door leading to the outside, E4 said she tried to redirect R5 not to go out but he refused. R5 was able to get out to the front of the building with E4. E4 continued to redirect R5. E4 said, she tried to get assistance from other staff through the walkie but no one responded. Since E4 and R5 were approaching the street, E4 said, she called for back up again. Staff responded and it required multiple staff to bring R5 back inside the establishment. R5 was brought back to the establishment without injury.

On 1/15/24 at 11:03am, E2 (Clinical Services Director) said, "The receptionist did not look at the monitor before she opened it. They are

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A4060	Continued From page 6 supposed to look at the monitor and make sure that there is no resident in the area. " On 1/15/25 at 11:36am, E6 (Receptionist) showed to surveyor feeds from the camera located above the locked door. E6 said, she can see if a resident is hovering around the door. "If a visitor wants to get out, I will usually wait at least 2 seconds before buzzing them out to make sure there is no resident coming from the other side following the visitor. I will not open the door, if I see a resident is with the visitor." R5's progress notes dated 12/12/24 indicated, R5 was exit seeking kept saying he wanted to go out to dollar store and go home.	A4060		
A9000	Section 295.9000 Physical Plant This Regulation is not met as evidenced by: Type 3 Violation Section 295.9000 Physical Plant n) The establishment shall maintain a means of unlocking all doors, which may be used in emergency situations or as provided in the establishment contract. This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to have key to unlock bathroom door and provide immediate assistance for one (R2) resident who had a fall inside the bathroom. This deficient practice has the probability to affect all residents.	A9000		

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A9000	Continued From page 7 Findings include: An onsite visit was conducted on 1/14/25 and 1/15/25. R2's Electronic Health Record (EHR) was reviewed. Per R2's face sheet, R2 was 101 years old at the time of incident. R2's diagnoses include but not limited to Unspecified Dementia. R2's notes indicated R2 was diagnosed of Cancer and passed away on 11/19/24. R2's notes dated 10/12/24 stated in part; "Writer heard a distant "help, help" ...the cries was coming from and traced it to the bathroom in the common area. Writer attempted to open the door in which it was locked and writer had no access to open it ...phone 911 paramedics arrived and was able to successfully open the door. Resident observed on the bathroom floor with her legs caught in her wheelchair pedals ...complained of side pain." R2 was sent to the hospital for evaluation. On 1/15/25 at 11:03am, E2 (Clinical Services Director) said, the bathroom door lock from the inside, and at that time they were having trouble with the lock, they did not have a key. On 1/15/25 at 12:17pm, communal bathroom where R2 fell was inspected, E5 opened the bathroom door using her key.	A9000		