STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A 000	Initial Comment Complaint Investigation 2575420/194492 - No Deficiency Facility Reported Incident of 3/31/2026/IL201196 - 295.4000 a)b), 295.3000a)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the facility failed to keep one (R2) of three residents safe while residing in the facility. This failure resulted in R2 sustaining a Traumatic Pneumothorax and fractures to left 5th, 6th, 7th, and 8th ribs after being hit by a facility dining cart when attempting to board the elevator. This failure created severe harm to R2. Findings include: R2 is a 97-year-old-female with move in date of	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 1 7/16/2020 with diagnosis of Essential (Primary) Hypertension, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Wheezing, Hyperlipidemia, Unspecified, Iron Deficiency Anemia, Unspecified, Age-Related Osteoporosis without Current Pathological Fracture, Heart Failure, Unspecified Facility Reported incident date 4/8/2026 documents in part: On 3/31/26, R2 sustained a fall at 5:45pm when she was attempting to get onto the elevator as personnel pushing a dining cart was exiting the elevator. R2's walker and the dining cart collided resulting in her losing balance and falling backwards. Upon assessment, R2 was noted on her right side with her walker nearby. She was wearing non-slip shoes. Resident complained of left upper back pain. 911 called and resident was transported to local hospital ER for further evaluation. MD and POA notified. Resident was evaluated and later admitted with a diagnosis of Traumatic Pneumothorax and Fractures to Left 5th, 6th, 7th and 8th ribs. Conclusion: R2 sustained a fall while attempting to board the elevator while a dining cart was exiting. 911 called and resident transported to (Local) ER. Resident was evaluated and admitted. Her return is anticipated anytime. Elevator education to be provided to resident upon her return, instructing that she waits to get on the elevator after others have exited. Safety education on elevator etiquette provided to staff and a new intervention of pulling carts instead of pushing them on and off elevators has been implemented. On 4/24/2025 at 2:53pm E4, Licensed Practical Nurse (LPN) stated, I was here the day R2 fell. I was the nurse in charge. I was called by the CNA	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 2	A3000		

she was on the scene and called me. I observed R2 on the floor on her right side in severe pain and I initiated an assessment and due to severe pain and guarding neuro assessment was limited, did spinal precaution and did not move her because I did not know how she landed. I assessed no bleeding; I called the doctor and informed him she was on the floor and in severe pain. I did not move her; doctor ordered her to be sent out for further treatment and evaluation. I called the POA (Power of Attorney) and he was in agreement and I called 911 and they arrived within 10 minutes. I do not recall her diagnosis. R2 was on the floor feet towards elevator, walker by her foot and wearing slip on shoes and hands underneath her. She was not able to say what happened, but she was in severe pain and guarding. E4 stated, he was told R2 was standing in front of the elevator E5 (Dietary Server) had a food cart and they came in contact, and she fell backwards and when I came to the scene she was on her right side. I got a statement from E5. E5 said he did not know she was standing there. R2 was in severe pain and all she was saying was get me out of here. R2 said her left scapula area she said there (where it was hurting). R2 was coming from the dining room on the 1st floor and probably going to her room on the 3rd floor. Interviews obtained was she was standing by the elevator. R2 was screaming in pain and dressed appropriately and wearing slip on shoes (open in the back). I filled out an incident report informed my E3, (Clinical Director Assisted Living). Later, I called the hospital, and they said she was being admitted and then I called the POA to let him know she was being admitted.

On 4/24/2026 at 3:24pm E5, Dietary Server stated, "I remember incident with R2. When I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 3	A3000		

finished serving on the second floor, I took the elevator along with the hotbox (food cart) back to the kitchen. I was taking the hotbox back to the kitchen when the elevator door opened on the first floor, I did not see anyone, so I proceeded to push the cart out of the elevator. While pushing the cart out of the elevator one hand on back and one hand on the side. I felt the cart collided with something and I stopped, and I checked and in front of the cart I saw a walker and R2 kind of fell backwards because she was in motion while I was looking to see what it was. I tried to assist and get her up because she was on her back, but I was unsuccessful in doing". E5 stated, he called the nurse, and the nurse called the ambulance. Other staff came, about 2 CNAs and another server came out. The nurse came very quickly and called the ambulance very quickly because she was crying. E5 stated, "Normally I take a look to see if anyone is there and then proceeded which is what I did but I did not see her. I did not see her walking. I was surprised and wondering what I could have hit because there was nothing there". E5 further stated, he is supposed to make sure no one is in your way then proceed out with hands in proper position and look out to see if someone is there. E5 stated, "I tried to get her up, but she was crying so much. I did not want to cause any more pain to her so with the advice of the CNA and others around me, they told me I should leave her on the floor because lifting her up could cause her more pain, so I decided it was wise to leave her". E5 stated, when he started, they went over the procedure and if someone is in extreme pain or experiencing pain to leave them because it can cause more pain and wait until professional gets here. R2 did not say anything just crying and not saying much. E5 stated, he gave a statement about what happened. They told me they would have to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 4	A3000		

report it, and someone would come in to do their own investigation. After that, they told me in the future instead of pushing cart out to pull cart out so I would be out of the elevator and have a better view.

On 4/24/2026 at 3:43 pm E6, Dining Service Supervisor stated that she was here that day (3/31/2026) and was the supervisor. She was in independent living and E5 came over and was explaining to her about an incident that happened. He said something about a lady falling and the cart colliding and he did not see her, so E6 went to look for herself and that is when E6 saw R2. R2 was on the ground, and the nurse was with her and the paramedics had been called. E5 said he was getting off the service elevator and he was coming off and she was coming on and her walker hit the hot box (food cart) and she fell back. The hot box is very tall, and you cannot see over it. They can push or pull the hot box. Residents will use the service elevator but ideally used for service elevator. That is the elevator we use due to too much traffic on the other elevators. When the cart if coming off the elevator, they should check to make sure no one is around. They can either get off and check or peek their head out and check. He said he did not see her. It was a nurse on duty that filed the report and got a written report from E5. I emailed E1(Administrator Associate/Executive Director), E2 (Director of Nursing) and our Executive Director about what happened. An in-service with dietary staff about the carts was done. Basically, they were told to be mindful and check surrounds before you move the cart. Now they pull cart off the elevator instead of pushing off elevator.

On 4/25/2026 at 11:37am E7, Certified Nursing Assistant stated, she is familiar with R2 and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 5 her CNA on 3/31/2026, but she was not there to witness it. E7 stated, she passed dinner trays around 5:30pm and residents went to the dining room. R2 was wheeled down to the first floor and E7 took her walker because she can walk. E7 told R2 she would be back to get her. R2 said ok. R2 usually will stay in dining room then go back. Around 5:50pm E7 went downstairs and R2 was laying on the ground face first on her stomach. The nurse was right there and called 911. The ambulance came and took her to hospital. R2 was going upstairs to her room. This is the elevator that she normally takes. R2 likes to walk a lot. She has never had any issue with falling. She was getting impatient because she did not want to wait. She knows where her room is. R2 did not say what happened but said she was hurting. E7 did not recall R2 saying what happened. The elevator that R2 was taking is close to R2's room. On 4/25/2026 at 12:04pm E3, Clinical Dir. Assisted Living/Memory Care stated she was familiar with R2 and the incident that occurred on 3/31/2026. R2 was in the dining room for dinner and staff brought her down for dinner and staff brought walker down with her. R2 can walk by herself with walker. R2 ate dinner in the dining room assigned CNA packed up dining trays for other residents and told R1 she would come back down for her (R2). While E7 was delivering room trays R2 got out of Wheelchair and got her walker and exited the dining room she was attempting to use the elevator. E5 was on elevator with dining cart and was exiting the elevator while R2 was attempting to enter the elevator bumping into R2 and bumping into her walker resulting in R2 falling. E3 stated, "I assume he exited without looking over cart to see if someone was there". This is an elevator that residents are able to use.	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 6 Staff should exit pulling the cart while standing in front of the cart so you can observe your field in front of you if the equipment/cart is tall enough to obstruct your vision. Based on nurse's incident report, reported that he (E5) was pushing the cart in front of him while exiting the elevator, he was behind the cart pushing out. Based on incident report, staff members in pantry and dining room responded to fall and notified the nurse immediately and nurse assessed R2 and due to her reports of pain called 911 to transport to R2. R2 transferred to ER and admitted for rib fractures and pneumothorax on the left side. We did elevator etiquette education with staff to stand back wait for doors to open letting passengers exit before entering, pressing buttons for people that cannot reach and holding doors open for residents that take longer to exit or enter elevator. Education with staff on pulling equipment and carts to not obscure their field of vision. Education was done with food service staff to pull carts off elevators so they can see if anyone is standing in front of elevator or attempting to board the elevator. R2's POA spoke to and E3 visited R2 in the hospital before coming back. When incident or accident occurs an incident report is completed. The nurse completed the initial incident report then the second portion is completed by E3 or E2, Director of Nursing (DON). I did not speak with server involved; I am not sure if he looked down hall prior to exiting with cart. On 4/25/2026 at 12:36pm E2, Director of Nursing (DON) stated, she was familiar with R2 and incident that occurred on 3/31/2026. It is my understanding that R2 was getting on elevator at the same time our dining staff (E5) was coming off the elevator with a hot box. The staff did not see her and the hotbox collided with her walker	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 7	A3000		

and she lost her balance and fell. The associate that was pushing the cart responded to her right away, nursing was notified and the nurse came to assess her and the aide as well and 911 was called. R2 was transferred to local hospital and admitted for traumatic pneumothorax and found out later she had fracture to left ribs. Nursing contacted POA and MD and we followed up with hospital. We did fall review to determine root cause analysis and did in-service for all staff regarding elevator etiquette and also in-serviced staff on standing in front of hot boxes and pulling off elevator instead of standing behind hot box and pushing off elevator. I followed up with E5 and said he was coming out of elevator and did not see her and walker and hot box collided. He was pushing hot box out of the elevator. All staff were in-serviced on how to move equipment. Signage and posted at elevators and residents spoke to about elevator etiquette.

On 4/25/2026 at 1:01pm E1 stated he is familiar with incident that occurred with R2 on 3/31/2026. R2 was getting on elevator and dietary staff was pushing cart off the elevator and the cart hit her walker and she fell backwards and sustained injuries to her rib fractures and pneumothorax. We did initial reportable and final and E3 and E2 discussed with staff and looked at interventions to put in place. We have gone through education and are making sure staff pull out instead of pushing out so there is visual control before moving out of the elevator and making sure people wait for others to exit prior to getting on elevator. E1 stated he was not sure exactly of dining staff's orientation and cannot valid if they had safety training on moving equipment. E2 and E3 did investigation. Elevator etiquette and moving of hot boxes. A resident can ride any elevator they want except for service elevator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 8 The elevator R2 was on was not a service elevator. Follow up Report by E2 on 4/13/2026 at 8:54am documented in part: On 3/31/2026, R2 sustained a fall at 5:45pm when she was attempting to get onto the elevator as personnel pushing a dining cart was exiting the elevator. R2's walker and the dining cart collided resulting in her losing balance and falling backwards. Upon assessment, R2 was noted on her right side with her walker nearby. She was wearing non-slip shoes. Resident complained of left upper back pain. 91I called and resident was transported to local Hospital ER for further evaluation. MD and POA notified. Resident was evaluated and later admitted with a diagnosis of Traumatic Pneumothorax and Fractures to Left 5th, 6th, 7th and 8th ribs. A thorough investigation was completed which included a review of the client's medical record and interview with staff, physician and resident. Conclusion: R2 sustained a fall while attempting to board the elevator while a dining cart was exiting. 911 called and resident transported to local ER. Resident was evaluated and admitted. Safety education on elevator etiquette provided to staff and a new intervention of pulling carts instead of pushing them on and off elevators has been implemented. The IDT has reviewed the fall and has updated the resident's care plan to reflect these changes. The resident and POA are in agreeance with the current plan of care and are supportive of the changes. Nurses note on 3/31/2026 at 5:45pm by E4 documents in part: At approximately 5:45 PM, the CNA notified nursing staff that the resident was found on the floor in front of the first-floor elevator near the main dining room. Upon arrival, the resident was observed lying on her right side. She	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 9	A3000		

was alert and verbally responsive. The resident was wearing slip-on shoes, and her walker was positioned near her feet. She was moaning and complained of pain in her left upper back. The resident was kept immobilized due to her reported pain. A full physical assessment could not be completed as the resident refused further examination. Per report from the kitchen staff member who witnessed the incident and was involved, the resident was standing near the elevator while the staff member exited with a food cart. The staff member reported being unaware that the resident was present. Contact occurred between the resident's walker and the food cart, after which the resident lost balance and fell backward. An order was received to transfer the resident to the emergency room for further evaluation and treatment. Emergency Medical Services (911) were called and arrived within approximately 10 minutes. A report was given, and the resident was transported to Emergency Room for further evaluation.

R2's Service Plan review completed 5/2/2025 documents in part:
Focus: Safety
Goal: To be safe while living in community
Interventions/Tasks: Safety Check every 2-3 hours Date initiated 9/12/2024
Mobility Date initiated: 7/20/2024
Goal: Will maintain independence for mobility.
Date Initiated: 07/20/2024 Target Date: 05/08/2025
AMBULATES WITH: 2 front wheel walker Date Initiated: 07/20/2024
MOBILITY: Requires Stand-By-Assistance Date Initiated: 12/26/2023

Facility Resident Handbook undated documents in part: For those who need help with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 10	A3000		

activities of daily life, Providence Life Services' Assist- ed Living communities ensure safety while preserving dignity. Assisted Living provides for needs as you being to require assistance with care.
LIVING ESTABLISHMENT CONTRACT
R3's contract documents in part: The Contract will begin July 16. 2020 ASSESSMENT: Within 30 days prior to the Resident's admission to Park Place of Elmhurst, the Resident must provide Park Place of Elmhurst with a comprehensive assessment that includes an evaluation of the Resident's physical, cognitive, and psychosocial condition, completed by a licensed physician. Park Place of Elmhurst reserves the right to determine if Resident meets the requirements for occupancy. Resident is required to annually provide a physician's comprehensive assessment to Park Place of Elmhurst. Based on this assessment, Park Place of Elmhurst shall develop a service plan, which shall be mutually agreed upon with the Resident. For the Resident to be accepted for residency or remain in residence in Park Place, Park Place of Elmhurst must be able to provide or secure appropriate services for the Resident'
Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS | LONG-TERM CARE dated (Rev. 11/18) documents (in part): Your rights to safety Your facility must be safe, clean, comfortable and homelike.

Illinois Department of Public Health Assisted Living in Illinois documents (in part) In Illinois, assisted living facilities are required to provide a safe environment for residents. This includes adherence to building codes related to accessibility, fire safety, and sanitation, such as adequate lighting, ventilation, and emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A3000	Continued From page 11 exits, including smoke detectors and fire extinguishers. Facilities must also ensure that the environment is safe, clean, comfortable, and homelike, with reasonable arrangements to meet residents' needs and choices. Dietary Aide Job Description dated 1/26 documents in part: The primary purpose of your job position is to provide assistance in all dietary functions as directed/instructed and in accordance with established dietary policies and procedures Duties and Responsibilities All dietary procedures are to be followed in accordance with established policies.	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.	A4000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A4000	Continued From page 12 b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure one (R3) of three residents' annual physical assessments were completed by a physician. This deficient practice affected one resident (R3) reviewed for physician assessment in a sample of three. Findings include: R3 is an 85-year-old male with move in date of 3/26/2026 with diagnosis that include Disorder of Muscle, Unspecified, Anemia, Unspecified, Chronic Venous Hypertension (Idiopathic) With Ulcer of Left Lower Extremity, Acute (Reversible) Ischemia of Large Intestine, Extent Unspecified, Duodenal Ulcer, Unspecified as Acute or Chronic, Without Hemorrhage or Perforation, Gout, Unspecified, Essential (Primary) Hypertension, Unspecified Asthma, Uncomplicated Polyneuropathy, Unspecified, Constipation, Unspecified, Insomnia, Unspecified, Allergic Rhinitis, Unspecified R3's Facility Health and Wellness Center Physician Certification dated 12/23/2025, signed by E14 (Advanced Nurse Practitioner), physician signature omitted. On 4/25/2026 at 2:02pm E2 stated, medical assessments are done prior to admission and annually. Sometimes the NP (Nurse Practitioner) does sign but we try to get the MD (Medical Doctor) to sign. MD is supposed to sign the	A4000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510264	A. BUILDING: _____ B. WING _____	C 04/26/2026

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

(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
A4000	Continued From page 13 certification. E2 reviewed physician certification for: R3 and confirmed physician certification was signed by a Nurse Practitioner, not physician. Facility Resident Handbook undated documents in part: ELIGIBILITY Park Place residents come from various social, economic, cultural, racial, and religious backgrounds. We offer services to members of the community without regard to race, color, national origin, age, sex, or disability. Eligibility to live at Park Place is based on (1) an evaluation conducted by the Assisted Living Clinical Director, and (2) an assessment conducted by a physician no more than 120 days prior to moving in. Residents must be free of communicable diseases, as determined by their physician. Physician assessments are required annually for all Park Place residents. Also, if we notice a significant change in the condition of any resident, we will require a physician assessment. We care about you as individuals and as a community, and this policy is designed to keep everyone at optimal health.	A4000		