

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510185	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2024
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NAME OF PROVIDER OR SUPPLIER CIEL AT PLAINFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 12446 S VAN DYKE ROAD PLAINFIELD, IL 60585
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(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 Original investigation of Complaint 2476271 / IL 176503 and FRI IL 177424. Complaint IL 176503 - 295.6000 a) 6) Cited FRI IL 177424 - No violations	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 6) The right to direct his or her own care and negotiate the terms of his or her own care; TYPE 3 VIOLATION Based on interviews and record review, the establishment failed to let one of three residents sampled (R1) , direct her own care. Findings include: R1's progress notes dated 8/4/24 notes resident had an unwitnessed fall and was discovered at approximately 7:25 A.M.. E3 (LPN) assessed R1 and since R1 was on hospice, she called R1's hospice company for instructions. Response from hospice reads, "Will come and assess. Resident	A6000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A6000	<p>Continued From page 1</p> <p>cannot be sent to the hospital due to resident is under hospice care."</p> <p>On 9/9/24 at 10:15 A.M., R1 stated that she remembers falling out of her wheelchair on the morning of 8/4/24. R1 stated that she does not know how it happened exactly but that her call pendant had fallen off, so she was unable to call for assistance. R1 stated that when staff found her on the floor, they called for an ambulance. R1 stated that she was having some pain, so when the EMT's asked if she wanted to go to the hospital, R1 told them she did. R1 stated that after the EMT's got her into the ambulance, the nurse (E3) came out and told them she was not allowed to go to the hospital because she was on hospice.</p> <p>On 9/9/24 at 9:05 A.M. Z1 (EMT Manager) stated that she was informed of the incident by her EMT's and that R1 did say that she wanted to go to the hospital on the morning of 8/4/24 and that they nurse (E4) made the EMT's unload R1 out of the ambulance and take her back into the facility. Z1 stated she has never heard of such a thing and that the resident should be able to make her own decision.</p> <p>EMT Incident Report regarding R1 on 8/4/24 reads, "Today we had an incident in which an elderly female had fallen. The female complained of right sided pain. After being assisted to her wheelchair and assessed, the patient stated she wanted to be transported to the hospital. The patient was awake, alert, and oriented to person, place, time and events. The patient denied striking her head or loss of consciousness. The patient and the staff on scene were unsure as to how long the patient</p>	A6000		

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A6000	<p>Continued From page 2</p> <p>had been down on the ground. The patient was also on the blood thinner Eliquis and lowdose Aspirin. The patient was moved to the ambulance where ALS procedures were initiated. Shortly after completing ALS procedures, the LPN entered the Ambulance and stated that the patient was in Hospice and could only be transported with Hospice's permission. The patient was taken back to her room and placed in the wheelchair. The patient was left in the care of staff member."</p> <p>On 9/9/24 at 11:50 A.M., E1 (Executive Director) stated that she was unaware that R1 had requested to go to the hospital on the morning of 8/4/24 and was not allowed to go. E1 stated that just because a resident is on hospice does not mean they cannot direct their own care and chose to go to the hospital for an evaluation.</p>	A6000		