

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Park Place Christian Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Euclid Avenue Elmhurst, IL 60126	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview and record review, the facility failed to treat residents with dignity while providing care.</p> <p>This applies to 2 of 2 residents (R24 and R16) reviewed for dignity in a sample of 15.</p> <p>The findings include:</p> <p>On 04/23/25 at 12:08 PM, V8 CNA (Certified Nurses' Assistant) was standing over R24 feeding him spoonful of a red thickened drink. V8 then went to another table and stood over R16 feeding her mashed potatoes, a green pureed food, and gave her a drink of a red liquid.</p> <p>On 04/24/25 at 10:17 AM, V2 DON (Director of Nursing) said that staff should be sitting while feeding residents to have a better visual observation of the resident and for the resident's dignity.</p> <p>The facility's Resident Rights and Responsibilities - Exhibit D policy (no dated shown) showed, These resident rights, policies and procedures ensure that each resident has a right to a dignified experience, self-determination and communication with the access to persons and services inside and outside the facility.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>4. On 04/23/25 at 11:36 AM, there was 1 bottle of antifungal powder on R1's bedside table, and 1 unopened vial of albuterol sulfate 2.5mg/3ml next to the nebulizing machine in a portable shelving unit. R1's 11/13/24 physician's order showed Albuterol Sulfate inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 3ml inhale orally via nebulizer every 6 hours as needed for wheezing. On 4/24/25 a review of R1's physician's orders did not show an order for antifungal powder.</p> <p>On 04/24/25 at 10:21 AM, V2 Director of Nursing (DON) said the reasons that medications should not be in the residents' rooms are for safety issues, someone else can use the medication and there is a risk of double dosing the medications or a drug interacting with other medications that are being given.</p> <p>5. 04/23/25 at 11:48 AM, one 3 oz. bottle of antifungal powder was on R15's over the bedside table. R15's 3/23/25 physician's order showed Miconazole External Powder 2% (Antifungal powder) apply to groin and folds as needed for itching (rash/redness)</p> <p>6. On 04/23/25 at 11:13 AM, there was 1 bottle of medicated shampoo in R24's bathroom. R24's 3/25/24 physician's orders showed Ketoconazole External Shampoo 2%. Apply to scalp topically in the morning every Tuesday and Friday for Seborrheic Dermatitis.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that resident medications were secured.</p> <p>This applies to 6 of 6 residents (R1, R8, R9, R15, R23 and R24) reviewed for medication storage in a sample of 15.</p> <p>Findings include:</p> <p>1. On 04/23/25 at 10:23 AM, located on the over bed table, R8 had a bottle of chlorpheniramine maleate 4mg (milligram) 100 count bottle, two 1 fl oz (fluid ounce) bottles of Sodium Carboxymethylcellulose, one bottle of Ketotifen fumarate 10ml (milliliter), one bottle of povidone 0.33 fl oz, and one 12 oz bottle of aluminum hydroxide / magnesium hydroxide / simethicone. R8 stated she uses the eye drops at night when her eyes are dry. V8 stated she takes a teaspoon of the aluminum hydroxide / magnesium hydroxide / simethicone before she eats, when she has acid reflux, or heart burn. V8 stated she has acid reflux or heart burn quite often. V8 stated the medications are just over the counter. V8 stated the medications have always been sitting out and the staff never asked her about them or said she couldn't have them or said they needed to be put away.</p> <p>The facility policy Medication Administration dated 5/9/2023 states medications are prepared and administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The medication storage is locked whenever unattended .</p> <p>2. On 04/23/25 at 11:01 AM, R23 had nystatin 15gm (gram) bottle and miconazole nitrate 3 oz on his nightstand.</p> <p>On 04/23/25 at 11:35 AM, R23 stated the facility staff placed the creams and powders in his room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R23 stated he does not apply any of the items on himself.</p> <p>On 04/23/25 at 12:02 PM, V2 DON (Director of Nursing) stated they were unaware of R8 and R23 having medications at their bedside.</p> <p>On 04/24/25 at 09:09 AM, R23 had two 2.5 oz tubes of miconazole nitrate ointment and on bottle of miconazole nitrate powder 3 oz on his nightstand. V13 RN (Registered Nurse) stated R23's daughter requested they be left at the bedside, but the medications should still be secured.</p> <p>3. On 4/23/2025 at 10:45 AM, R9 was in bed. R9's bedside table had unsecured bottles of Tylenol (acetaminophen) 500mg (milligram) tablets and Systane eye drops. R9's Tylenol and Systane medications were filled and open. R9 said she had brought the medications from home for her personal use.</p> <p>On 4/24/2025 at 11:40 AM, V2 (DON) said R9's medications should have been properly secured in a locked drawer in her room to ensure the safety of other residents.</p> <p>R9's Order Summary Report dated 4/24/2025 had active orders for Systane Ophthalmic Solution 0.4-0.3% for 1 drop to both eyes two times a day and Tylenol Extra Strength 500 MG give 1 tablet by mouth every 6 hours as needed for pain. The orders indicated R9's medications could be self-administered and kept at the bedside.</p> <p>The facility policy Medication-Self Administration states medication for self-administration will be stored in the medication cart and will be placed in appropriate medication cups and brought to the resident by the licensed nurse for resident administration. If the resident requests medication to be left in the room, a locked, permanently affixed box in the resident room must be provided for this purpose.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to label/date/seal/store food items, remove expired items, and sanitize the food preparation counter in the facility kitchen.</p> <p>This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen.</p> <p>Findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated 4/23/25 documents that the total census was 36 residents. On 4/23/25 at 11:00 AM, V4 (Director of Dining Services) said all 36 residents eat from the facility kitchen.</p> <p>1. On 4/23/25 at 10:58 AM, V4 (Director of Dining Services) was asked to test the sanitation bucket in the kitchen prep area. V4 picked the bucket of sanitizer solution up from the floor, placed it on the preparation counter next to cook who was prepping desserts, and V4 tested strip. V4 then removed the sanitizer solution bucket from the prep counter and placed it back on the floor and walked away. V4 then returned to the prep area and waited for surveyor to continue kitchen tour. Surveyor then had to ask V4 to sanitize the prep counter where he had placed the sanitizer bucket from the floor.</p> <p>On 4/24/25 at 12:28 PM, V4 said the food preparation counter should be sanitized after a bucket from the floor is placed on it to minimize the chance of bacteria from counter contaminating food items.</p> <p>The facility's policy titled, Cleanliness and Sanitation of Service Areas last reviewed 10/24 states, Policy: The cleanliness and sanitation of the serving area is to be maintained . Procedures: .The Dining Services Manager/designee will: 1. Monitor employees to ensure that the meal serving area is properly maintained and all foods are served safely .</p> <p>2. On 4/23/25 starting at 10:09 AM, the facility kitchen was toured in the presence of V4 and the following was found:</p> <p>In walk-in cooler:</p> <p>a. Medium sized silver bin of crab salad, no label or date</p> <p>b. Small silver bin of tomato paste with expiration date of 4/19/25; expired.</p> <p>c. Small silver bin of ground beef, no label or date.</p> <p>d. Small silver bin labeled straw (strawberry) with expiration date 4/15/25; expired.</p> <p>e. A large shallow tray of 18 leftover sausage links, uncovered and sitting in a thick white congealed substance.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>f. A large tray of leftover prime rib, not sealed, with multiple small remnants of beef in bottom of tray with thick white congealed substance surrounding.</p> <p>In roll-in prep cooler:</p> <p>g. 2 bags of meat, unlabeled and undated.</p> <p>h. A small silver bin of crab salad dated 5/23/25 good through 5/28/25. V4 was asked how long prepared salads are good in the refrigerator for and he said 3 days; crab salad was labeled wrong.</p> <p>In reach-in freezer:</p> <p>i. Five pies, unlabeled, undated, and uncovered.</p> <p>j. Medium sized bin with 5 salmon filets, unlabeled and undated.</p> <p>In dry storage:</p> <p>k. A 25 pound box with bag of semisweet chocolate chips, not sealed and open to air. V4 said the bag being open was risk for contamination.</p> <p>l. A 10 pound box with a bag of graham crumbs, not sealed and open to air.</p> <p>In walk-in produce cooler:</p> <p>m. A medium tray of diced mushrooms, unlabeled and undated.</p> <p>In dairy cooler:</p> <p>n. A 32 ounce carton of heavy whipping cream left opened, not sealed.</p> <p>On 4/24/25 at 12:28 PM, V4 said all food items in the kitchen should be labeled and dated to make sure they are not serving the residents food that will make them sick. V4 said all opened and leftover food items should be sealed/covered to prevent contamination and foodborne illness. V4 said prepared salads, such as crab salad, is only good for 3 days and there is potential for resident illness if served after 3 days. V4 said expired food items should be removed from food storage as soon as they expire so the kitchen staff doesn't accidentally serve the expired food item and cause resident illness.</p> <p>The facility's policy titled, Food Storage Expiration Dates last reviewed 10/24 states, Policy: All opened food that is placed into storage shall be labeled with the product name, date opened and/or expiration, or use-by date . Procedures: Foods that expire 3 days after opening: leftover foods, prepared salads .</p> <p>The facility's policy titled, Storage last reviewed 10/24 states, Policy: All food, chemicals and supplies should be stored in a manner that ensures quality and maximizes safety of the food served .Procedures: .7. Store food in original container if the container is clean, dry and intact. If necessary, repackage food in clean, well-labeled containers using food storage label .Storerroom Sanitation: .2. Dispose of items that are beyond the expiration or use-by dates .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, and record reviews, the facility failed to mitigate the risk of cross contamination during resident care and during handling of soiled clothing/materials.</p> <p>This failure applies to 4 of 4 residents (R24, R16, R84, R8) reviewed for hand hygiene, and all 36 residents in the facility for soiled linen handling.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated 4/23/25 documents that the total census was 36 residents.</p> <p>The findings include:</p> <p>1. On 04/24/25 at 09:17 AM, V3 (Wound Nurse) and V9 (Nurse) were providing wound care and incontinence care for R24. R24 had a pressure wound to his left gluteal fold. V9 pushed a garbage can toward V3 with her foot. V3 used her right hand and picked up the garbage can and placed the can next to her. V3 then with her unclean gloved hands opens R24's brief and then touches R24's pressure wound spreading the wound open to examine the wound. V3 described the wound drainage and discarded her gloves in the garbage can, cleaned her hands, put on new gloves and provided wound care. After providing wound care the nurses provided incontinence care for R24 because R24 urinated and had a bowel movement while they were providing wound care. After V3 had cleaned stool from R24's buttocks, she removed her gloves, cleaned her hands put on new gloves. V3 pushed a clean brief under R24 and then tucked the soiled brief under R24, then removed the soiled brief. After handling the soiled brief and without changing her gloves or performing hand hygiene, V3 turned R24 in his bed, finished attaching the clean brief, repositioned R24 in the bed, adjusted R24's gown, pulled R24's linen on him, and then adjusted a towel that was placed under R24 chin.</p> <p>On 04/24/25 at 09:45 AM, V3 said that she should not have touched the wound with the gloved hands after she picked up the garbage can to prevent cross-contamination. V3 said that after removing the soiled brief, she should have removed her gloves, cleaned her hands, and put on new gloves to prevent infections.</p> <p>On 04/24/25 at 10:25 AM, V2 (DON) said that V3 should have taken her gloves off and performed hand hygiene and then put new gloves on after picking up the garbage can and before touching the wound for infection control. V2 said that V3 should have removed her gloves and cleaned her hands and put on new gloves after touching the soiled brief before touching clean areas for infection control.</p> <p>The facility's Infection Control Nursing Procedures, Subject: Hand Washing (reviewed date 12/24) showed the purpose of hand washing is considered one of the most effective infection control measures. Frequency: after handling any contaminated items, after contact with inanimate objects or immediate vicinity of a client, before and after contact with a client's intact skin, during client care, after accidental contact with any bodily fluids, mucous membranes, non intact skin or wound dressings, if hands will be moving from a contaminated body site to a clean body site, during client care, before and after using gloves, handling food, client care, and in food service .</p> <p>2. On 04/23/25 at 12:08 PM, V8 CNA (Certified Nurse's Assistant) was feeding R24 with her right-hand 2 spoonful of a red drink, the drink had been thickened. Then V8 goes to R16 and starts to feed R16 using her right hand. V8 gave R16 a spoonful of mashed potatoes then a drink, still using her right hand, then gives her a spoonful of a green pureed substance again with her right hand. V8 did not</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>clean her hands between feeding R24 and R16.</p> <p>3. On 04/23/25 at 12:12 PM, V9 (Nurse) was sitting at a table between R24 and R84 feeding R24 and R84 using her right hand for both residents. V9 did not clean her hands in-between feeding them. V9 using her right hand gave R24 a spoonful of brown pureed food then put a spoonful of green pureed food into R84's mouth, then back to R24 and gave R24 another spoonful of brown pureed food, only using her right hand. V9 used her right hand again to give R84 a drink of a red liquid, and then gave R24 a spoonful of a red thickened drink. V9 did not clean her hands in between feeding the residents.</p> <p>On 04/24/25 at 10:17 AM, V2 DON (Director of Nursing) said that the staff should have cleaned their hands when going from one resident to another. V2 said that this should be done for infection control and cross-contamination.</p> <p>4. On 04/24/25 at 10:41 AM - 11:14 AM, a tour of the laundry room was conducted with V2 Director of Nursing (DON) present. There were two 50-gallon containers with soiled mop heads and other cleaning items in it and the containers did not have lids on them waiting to be washed. There was an open bag of soiled clothing on the floor by the washing machines. V2 (DON) said that the 50-gallon container should have a lid to contain bacteria and the soiled clothing on the floor should not be there because there is a potential for spreading bacteria, it can get on staff's shoes and then they go out on the floor and spread the bacteria on the floor. Then at 11:06 AM, during the tour of the laundry room, V6 (Housekeeper) brings an open bag of dirty clothing protectors in and drops it on the floor in front of the washing machines.</p> <p>The facility's Soiled Laundry Transport policy dated review date 4/2025 showed soiled linens are to be transported to laundry area in a secure manner. While in laundry room, secure the cover to the soil laundry cart. Place the soiled laundry into a cart or switch with empty cart and immediately re-secure the lid to the cart.</p> <p>5. On 04/24/25 at 12:55 PM, V11 and V12 (CNAs-Certified Nursing Assistant) assisted during R8's incontinence care. With gloved hands, V11 and V12 removed R8's pants and soiled disposable undergarment. V11 wiped R8's vaginal area with gloved hands, then removed the soiled gloves and retrieved more gloves from a box on the wall and placed them in her right shirt pocket. V11 put on a new pair of gloves and wiped R8's rectum. V11 removed her gloves, washed her hands, and put a new pair of gloves on, and placed a clean disposable brief under R8. V11 took A and D ointment from a jar and applied to R8's vaginal area with her right gloved hand. V11 removed that glove and put on a glove she took from her right shirt pocket. V11 then applied A and D ointment on R8's buttocks and rectum, removed the soiled gloves, and put on gloves from her shirt pocket. V11 and V12 then fastened R8's brief and assisted her to position in bed. V11 and V12 both removed their gloves. V12 then put another pair of gloves on to close R8's window blinds.</p> <p>On 04/24/25 at 01:17 PM, V11 CNA stated she cleans her hands prior to providing care but does not need to clean her hands every time she removes her gloves only when placing a new disposable brief.</p> <p>On 04/24/25 at 03:23 PM, V2 DON (Director of Nursing) stated improper hand hygiene during incontinence care can contribute to the development of urinary tract infections.</p>		