STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004550	A. BUILDING: _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY FAMILY VILLA	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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S 000	Initial Comments Complaint # 1896728/IL106525 # 1896621/IL106410	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These regulations are not met as evidenced by: Based on interview, and record review, the facility failed to follow their Falls Policy and failed to have appropriate interventions in place for 3 of 4 residents (R1, R2, R3) reviewed for falls in a total sample of 4. This failure resulted in R1 sustaining a right subdural hematoma which led to death, R2 sustaining a left hip fracture in four places, and R3 sustaining a right forehead hematoma.In addition the facility the failed to obtain STAT (immediate) radiology services in a timely manner for 1 of 4 residents (R2) reviewed for falls in a total sample of 4. This failure resulted in R2 waiting 8 hours to receive radiology services after fall.	S9999		

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Findings Include:

Example 1:
A Nursing note dated 8/23/18 documents R1 was found to be crawling on the floor out of the room by the certified nursing assistant (CNA) around 4:30AM. R1 was attempting to get out of bed to go to the bathroom and fell. R1 stated R1's head hit the floor. R1 had a big bump on the right forehead with minimal bleeding. The medical doctor (MD) ordered for R1 to be sent to the hospital. An Unusual Occurrence Notification Worksheet dated 8/23/18 documents R1 had a fall as described in the Nursing note from 8/23/18, an investigation was initiated and IDPH was notified.

A hospital record dated 8/23/18 documents a CT scan revealed a large right subdural bleed that had the possibility of being even closer to the brain with a midline shift (a shift of the brain past the center line). R1's family member made confirmation that R1 was not interested in surgery or any surgical intervention. R1 taken home by family on hospice care. R1 expired on 9/7/18. A death certificate dated 9/12/18 documents the cause of death for R1 was due to complications of a subdural hematoma and a fall.

On 10/18/18 at 1:26PM, V5 (CNA) stated, "At 2:00AM, R1 was in bed when I checked. I was in another room when R1 fell. We toilet R1 every two hours, and R1 wears a helmet. When we put R1 on the toilet after the fall, the helmet was off."

On 10/19/18 at 11:08AM, V6 (CNA) stated, "I found R1 in the hallway sitting on the floor. R1 had a bruise on her head. The interventions in

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place for R1 were a helmet, floor mats, and checking on R1 almost hourly. When I found R1, the helmet was off."

A Care Plan Baseline dated 7/30/18 documents R1 was at risk for falls, and the interventions include: bilateral floor mats, bed in low position, toileting plan, helmet to be worn and removed for skin checks and hygiene. A Toilet Schedule Flow Sheet dated 8/2018 documents that R1 should be toileted when awake during the early morning hours. It is noted R1 usually goes to the toilet every two hours during bedtime. Also, check placement of the helmet at least every 2 hours particularly if in bed. R1 was toileted at 12:30AM, asleep at 1:30AM, and no further documentation shows R1 was rounded on until R1 was found on the floor at 4:30AM. A Resident Care Plan Flow Sheet dated 8/2018 documents rounds are needed frequently when R1 in room, bilateral floor mats in place, bed in low position, and helmet on at all times. The helmet position and skin/circulation checks are every hour. R1 should be kept in the line of sight is possible. No documentation provided on the night shift (11pm-7am) for checking R1's helmet. A Fall Risk Assessment dated 8/4/18 documents R1 was a high fall risk.

Example 2:
A Nursing note dated 10/6/18 at 10:00PM documents R2 was moved from allocated room to another bedroom for the night due to a roommate disturbance. A Nursing note dated 10/6/18 at 5:00AM documents CNA found R2 in room sitting on the floor next to the bed. A floor mat was in place and the bed was in the lowest position. R2 was complaining of left hip pain and left knee pain. The MD was notified, and a STAT

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(immediately) x-ray was ordered. An Unusual Occurrence Notification Worksheet dated 10/6/18 documents R2 fell as described in the Nursing note from 10/6/18, an investigation was initiated and IDPH was notified.

A Nursing note dated 10/6/18 at 9:15AM documents R2 complained of pain in the left hip and left knee. Tylenol was given with only some pain relief noted per the resident.

A Nursing note dated 10/6/18 at 12:00PM documents that staff called to check the status of the x-ray technician arrival and was still waiting for a return call.

The diagnostic company was called at 8:30AM and told us they would be there within the hour. At 12:00PM, the company was called back, and they said they never received a message from before. Finally at 1:00PM, I just asked to have R2 taken to the hospital. R2 was finally transferred at 1:30PM."

A Nursing note dated 10/6/18 at 1:00PM documents that the Physician was notified of the x-ray not being done and orders were received to transfer the resident to the hospital for evaluation and treatment.

On 10/19/18 at 12:56PM, V8 (CNA) stated, "I know they were calling the x-ray people all day. They finally showed up when the ambulance got here to transport R2."

On 10/19/18 at 1:12PM, V9 (CNA) stated, "I went in R2's room and found R2 sitting on the floor at the foot of the bed. We tried to get R2 up, but R2 was in too much pain."

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A hospital record dated 10/6/18-10/12/18 documents the hip x-ray revealed an acute mildly displaced 4-part fracture of the left hip. R2 received surgery on 10/7/18 to repair the left hip. On 10/12/18, a fracture of the left clavicle and acromial process was found.

On 10/19/18 at 12:14PM, V7 (family member) stated, "They put R2 on a high fall risk. They gave R2 two floor mats with a concave mattress and put the bed in the lowest position. R2 ended up being moved to a different room that night because the roommate was dying, and we wanted the roommate to have some privacy. When I got there at 6:30AM and went to the room that R2 was moved to, there was no concave mattress on the bed, and only 1 floor mat was down on the floor."

On 10/19/18 at 12:56PM, V8 (CNA) stated, "We put R2 back in the bed with the regular mattress, and there was one floor mat on the floor."

On 10/19/18 at 1:12PM, V9 (CNA) stated, "I went in R2's room and found R2 sitting on the floor at the foot of the bed. R2 was moved that night to a different room. I don't recall R2 having a special mattress when R2 was found on the floor. There was only 1 floor mat that I saw."

On 10/19/18 at 1:51PM, V11 (Registered Nurse) stated, "I came into the room after the CNA called me, and R2 was lying on the floor toward the foot of the bed. R2 had one floor mat on the right side. I didn't know R2 was supposed to have the concave mattress until later after the fall. When the room was changed, the mattress wasn't brought over, and I didn't know about it."

On 10/19/18 at 2:09PM, V12 (Licensed Practical

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Nurse) stated, "R2 already fell when I arrived and I found out in report a STAT x-ray was ordered. I called the x-ray company around 9:00AM, and they told me they would be here at 12:00PM. They still weren't here at 12:00PM so R2's family member accepted the offer to transfer to the hospital. We were told the x-ray company might be stuck in traffic. STAT x-rays are usually done in a couple of hours."

On 10/23/18 at 10:13AM, V3 (DON) stated, "We were told by the company they might be stuck in traffic. It normally takes two, maybe three hours to get a STAT x-ray done. I'm not sure if the nurse notified the doctor when they still weren't here. At 12:00PM, we decided to send the resident out to the hospital."

A Care Plan Baseline dated 10/5/18 documents R2 is to have two floor mats, bed in low position, a concave mattress, and one person assist with the walker. It also documents R2 is a high fall risk.

Example 3:
A Nursing note dated 10/17/18 documents around 3:15AM, R3 was brought by the CNA to the bathroom via wheelchair. R3 stood up from the toilet unassisted and fell to the floor hitting the right side of head. R3 was transferred to the hospital for evaluation. R3's care plan and incident report reviewed. The care plan dated 10/9/18 documents R3 must wear the helmet when up out of bed.

R3 was observed on 10/18/18 at approximately 11:43AM lying in bed. Fall interventions noted in placed. R3 stated, "I fell earlier this week during the night. I had a seizure and fell. I had to go to

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S9999	Continued From page 7 the bathroom, and the CNA got me up. I wear a helmet when I get up, but the helmet was not on that night." On 10/19/18 at 1:32PM V10 (Registered Nurse) stated, "R3 was seizing in front of the toilet. R3 denied a headache, but the right forehead had a bump. R3 is supposed to wear a helmet every time R2 gets out of bed, but I was told the CNA forgot to put it on before R3 was assisted to the bathroom." A policy titled "Fall Preventions and Management" dated 2/4/2014 and revised 11/27/2017 documents that's it is the responsibility of the unit nurse to make sure the appropriate interventions and safety equipment are in place, and it is the responsibility of the unit nurse and CNA to ensure that the care plan safety interventions are followed. (A)	S9999		