PRINTED: 11/21/2018 FORM APPROVED

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		IL6012678	B. WING		10/26	6/2018
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
PRESEN	CE VILLA FRANCISC	AN 210 NORT JOLIET, II		IELD AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	N SHOULD BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure a	nd Certification Survey				
\$9999	Final Observations		\$9999			
	Statement of Licens	sure Violations				
	300.1210a) 300.1210b)5) 300.1210c) 300.1210d)3)6) 300.3240a)					
	Section 300.1210 General Requirements for Nursing and Personal Care					
	with the participation resident's guardian applicable, must decomprehensive car includes measurable meet the resident's and psychosocial noresident's compreheallow the resident to practicable level of provide for dischargestrictive setting by needs. The assess the active participation	Resident Care Plan. A facility, in of the resident and the or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which is attain or maintain the highest independent functioning, and ge planning to the least assed on the resident's care sment shall be developed with tion of the resident and the or representative, as				
	b) The facility shall and services to atta practicable physica well-being of the re	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care		Attachment Statement of Licensure		ons

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/14/18

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: B. WING IL6012678 10/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN **JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6012678 10/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN **JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidence by: Based on observation, interview and record review the facility failed to identify the cause of an injury for one resident (R96). R96 sustained a fracture of the right distal leg caused by trauma. The facility also failed to transfer one resident (R13) in a safe manner. R 96 and R13 are two of four residents reviewed for safe transfers in the sample of 20. The findings include: 1) On 10/23/2018 at 1 PM, R96 was observed lying in bed. R96 was confused. When V11 (Certified Nurse Aide) pulled back her covers. R96's lower right leg had an ace wrap from her foot up her leg. V11 stated she did not know what happened to her. V10, (R96's daughter) came to visit on 10/23/2018 at 12 PM. V10 said, "My mother's leg got fractured; but no one knows how it happened. I believe someone injured my mother while she was being transferred using the lift. I have seen some of the certified nurse aides transfer her without using the lift, two aides on each side transferring her from bed to her chair. I tell them that's not the way you do it, but they said we can do it this way. I have seen other staff transfer with the lift, but don't support her feet. I was here one weekend and saw that my mother's leg was swollen and red and I told the nurse. She did the doppler and nothing was found. But an x-ray was done later and showed she had a fracture." V10 said she was told by the doctor treating R96's fracture that it was the result of an injury.

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6012678 10/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN **JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 V7 (nurse) taking care of R96 on 10/16/2018, was interviewed on 10/23/2018 at 2:30 PM. V7 said no one told her that R96 had a fall or incident. V7 stated, "She's bed bound unless we get her out of bed. She's not bearing weight. If she did not get hurt during a transfer with the lift, what could it be?" V7 stated the staff received training using the lift after R96 was injured. The nurse practitioner (V4) was interviewed on 10/25/2018 at 12:30 PM. V4 said she was called the weekend R96 had bruising and swelling. V4 gave the order for R96's x ray and transfer to the hospital. V4 stated, "I have no idea how that happened (R96's fracture). I was told (R96) had bruising, redness and swelling ... The bruising to me indicated it could be from an injury ... I thought (R96) had an injury ..." V8, V9 and V6 (certified nurse's aides) that work on R96's unit, were interviewed on 10/24/2018. They gave the following statements: At 1:30 PM. V8 said, "there was training given after R96 was injured." At 1:25 PM V9 stated, "I had training on how to use the mechanical lifts last week after R96 broke (R96's) foot." At 1:20 PM V6 (restorative CNA) said, "We did the training last week. There were 2 different sessions. We did it because R96 broke (R96's) foot. I retrained the CNA's." V5 is one of the nurses working on R96's unit. V5 was interviewed on 10/24/2018 at 1 PM. V5 stated, "They told us all to do the lift training right after R96 fractured her foot."

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V2, DON (Director of Nursing) was interviewed on 10/25/2018 at 2:46 PM. V2 said, "My conclusion was that R96's injury was caused by her severe osteopenia." V2 could not identify or explain what

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
7			A. BUILDING		001111			
5		IL6012678	B. WING		10/26/2018			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
PRESEN	PRESENCE VILLA FRANCISCAN 210 NORTH SPRINGFIELD AVENUE							
JOLIET, IL 60435								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
S9999	Continued From pa	ge 4	S9999					
	diagnostic assessme R96's fracture was Then V2 said, "R96 happened when shusing the full body to R96 up every day to could have happen given an in-service mechanical lifts after R96's Face Sheet state facility on 10/27 including Dementia Gastrostomy Feedi Disorder, Hyperten	nent was done to support that due to "severe osteopenia." b's fracture could have e was transferred by staff mechanical lift. The aides get o her chair and her fracture ed during a transfer. Staff was and training on proper use of er R96 was injured."						
	2018 documents R	ta Set dated September 28, 96 with severe cognitive equiring extensive assistance ers.						
	has a self-care defi assistance for trans On October 25, 20	ated 10/12/2018, shows R96 icit requiring extensive sfers using a mechanical lift. 18 at 10:02am, V2 (Director of taff persons are required to mechanical lift.						
	Unknown Origin, da following: "R96 no 2018 to have some right lower extremit nurse practitioner a bilaterally as well a extremity. After x-noted that patient h	vestigation into her Injury of ate 10/16/2018, showed the ted on Monday October 15, a redness and swelling to R96's by by nurse. RN had called and asked for Doppler studies s x-ray of (R96's) right lower ray report came back, it was had a comminuted fracture of s and an un-displaced						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			DATE SURVEY COMPLETED	
		IL6012678	B. WING		10/2	6/2018	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  210 NORTH SPRINGFIELD AVENUE  JOLIET, IL 60435							
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S9999	transverse fracture How Was Situation completed on unit to (mechanical) lift witourrently with this pages and the demonstrate lateral malleolus ar fracture of distal er swelling around rig. The U.S. National I MedlinePlus.gov Was comminuted fracture been fractured into makes reference to lot of force for som serious fall can cate.  2) 10/23/18 at 2:00 reclining wheelcha Assistants) placed R13 and lifted R13 bed. During this to was resting across bottom was hanging the sling. V13 states sling correctly under reclining wheelcha of the sling should to support R13 dur.  R13's Minimum Dadocuments R13 re assistance of 2 states Plan for Falls date.	of the distal end of the tibia Handled:In-services coday for transfers using the th all employees working catient (R96) " eport, dated, 10/15/2018, caphic examination of the right as comminuted fractures of and undisplaced transverse and of tibia. There is soft tissue th ankle."	S9999				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING\_ IL6012678 10/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN JOLIET, IL 60435 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 (B)

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