PRINTED: 04/26/2018 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: __ C B. WING IL6004766 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **222 NORTH HAMMES** PARC AT JOLIET, THE **JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 1871144/IL100458 \$9999 Final Observations S9999 Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 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: 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

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

6) All necessary precautions shall be taken to assure that the residents' environment remains

care shall include, at a minimum, the following

and shall be practiced on a 24-hour,

seven-day-a-week basis:

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

04/01/18

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: C B. WING IL6004766 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 NORTH HAMMES PARC AT JOLIET, THE **JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure transfer of 1 resident (R8) with two assistants and failed to provide supervision for 1 resident (R7) at risk for falls while ambulating. This applies to 2 of 3 residents (R7 and R8) reviewed for falls. This failure resulted in R8 fracturing R8's right femur. The findings include: 1) R8 was admitted to the facility March 15, 2010 per the admission face sheet. The physician orders dated February 6, 2018 through March 6, 2018 showed that R8 had diagnoses of chronic lung disease, fracture left femur, carotid artery disease, anemia, cellulitis right lower extremity, pressure ulcer, urinary retention, fracture of right lower femur. The fall risk assessment dated October 19, 2017 showed that R8 was at high risk for falls.

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note dated January 17, 2018 5:15 am that R8

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independently."

provided for each resident. V3 stated, "R8 should

2) R7 was admitted to the facility November 21,

The physician order sheet dated February 6,

have been a two assist transfer. The CNA (Certified Nursing Assistant) transferred R8

2016 per the admission face sheet.

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through February 7, 2018 showed no nursing

assessment information.

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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: C B. WING IL6004766 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 NORTH HAMMES PARC AT JOLIET, THE **JOLIET. IL 60435** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 6 S9999 showed that R7 was on the fall prevention program. Fall risk observation assessment dated February 24, 2018 (post injury) showed that balance and gait were not assessed. The assessment showed that R7 was unable to ambulate without assistance. The report showed the care plan was not updated and to continue with present care plan. The current care plan for fall prevention in R7's clinical record showed that R7 required the assistance of staff for ambulation. Some of the interventions added for fall prevention were not individualized to meet R7's abilities such as comprehending education and remembering instructions. Interventions in the care plan dated February 28, 2018 showed that 1 staff were to assist R7 with transfers and have R1 use a wheelchair. On March 1, 2018 at 3:50 pm V7 LPN (Licensed Practical Nurse) said that R7 was very mobile. V7 said R7 liked to dance and that R7 was usually put around other residents. V7 stated, "R7 needs to be watched all the time." On March 1, 2018 at 12:07 pm V3 DON (Director of Nursing) stated, "R7 is supervision with limited assistance." V3 said the family reported the fall. V3 said that prior to the injury/fall R7 was able to ambulate without assistance. (A)

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