STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: ______ B. WING ______	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE DOWNERS GROVE	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

(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
S 000	Initial Comments Annual Certification and Licensure	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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
01/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

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 requirements were not met as evidenced by:

Based on interview and record review, the facility failed to utilize a gait belt during a transfer and failed to provide assistance to one resident with ADLs (activities of daily living). These failures resulted in R66 sustaining a fall while in the washroom and sustaining a femur fracture.

These failures affect 1 out of 4 residents (R66) reviewed for falls out of a sample of 19.

The findings include:

R66's incident report dated November 8, 2017 documents that R66 fell in the washroom with the CNA (certified nurse's aid) present.. Upon

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S9999	Continued From page 2	S9999		

assessment, other than an elbow abrasion, R66 did not complain of pain and appeared to have no injury. Nursing notes timed at 8:20 AM on November 8, 2017 indicate that R66 fell at approximately 2:20 AM and by 6:00 AM, R66 did complain of pain to her right thigh, and swelling was noted, as well as shortening of her right leg. R66's physician was notified and she was transferred to the hospital for evaluation. R66 was diagnosed with a femur fracture.

On January 11, 2018, V6 (LPN) stated that when she arrived to work on the morning of November 8. 2017, she was advised of R66's fall by night shift staff. She was advised that V5 (former CNA-certified nurse's assistant). had been caring for R66 that night. V6 went to assess R66 and notified the physician that R66 now had pain and swelling. She then began to investigate the incident and how it had occurred and spoke to V5 over the telephone. V6 asked V5 about the circumstances of the fall. V5 admitted to V6 that she had not used a gait belt when she transferred R66 in to the washroom.V5 told her that the resident had been holding on to the grab bar but let go to pull her pants up and lost her balance. She was not able to completely stop the fall but helped to ease R66 to the floor. V6 stated that the facility policy is that gait belts are to be used for all resident transfers. V6 also stated that V5 no longer works at the facility and was terminated as a result of this incident, due to not using the gait belt and because it was felt that V5 could have provided more assistance to R66 by helping pull up R66's pants. V6 stated that if V5 had used the gait belt or even had assisted R66 with pulling up her pants, she would have had her hands on R66 and might have been able to stop R66 from losing her balance and falling.

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S9999	Continued From page 3	S9999		

Handwritten statement completed on November 11, 2017 by V5 indicates that R66 was finished using the washroom and was pulling up her pajama pants and lost her balance. V5 stated she caught R66 before she fell completely to the floor so she could land on her bottom. V5's personnel file reflects that V5 was terminated on November 15, 2017.

R66's MDS (Minimum Data Set) of September 30, 2017 scores R66 as a 2/2 for most ADLs, including transfers, dressing and toilet use. This indicates that R66 was a one person physical assist for these tasks.

Facility policy on gait belts states tht gait belts are mandatory for all residents who need assistance with ambulation or transfers..

R66's face sheet documents that she was admitted to the facility July 1, 2017 and is 100 years old. R66 was identified as being at risk for falls with an initial fall care plan developed. R66 was noted to have several falls (10/16/17, 10/23/17, 10/11/17) prior to the November 8, 2017 fall, making R66 at high risk for falls.

R66's diagnosis list reflects that the diagnosis of right femur fracture was added on November 11, 2017.

(A)