STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004766	A. BUILDING: _____ B. WING _____	C 07/26/2021

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S 000	Initial Comments Complaint Investigation 2174821/IL135807 2175097/IL136160	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210d)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the ordered treatment to a resident's burn wounds. This applies to 1 of 2 residents (R9) reviewed for burn incidents in the sample of 11. This failure resulted in the delayed healing of R9's burn wounds. Findings include: R9 has multiple diagnoses which included cerebral infarction due to thrombosis of the left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, morbid obesity (severe) due to excess calories, diabetes mellitus with hyperglycemia, chronic pain, neurogenic bladder, neuromuscular dysfunction of bladder and bipolar disorder, based on the face sheet. R9's quarterly MDS (Minimum Data Set) dated 5/21/21 shows that the resident is cognitively intact. R9's MDS shows that the resident would require extensive assistance from the staff with	S9999		

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S9999	Continued From page 2 bed mobility and toilet use, total assistance from the staff during transfer and bathing/sponge bath, and supervision during eating and personal hygiene. On 7/21/21 at 9:41 AM, R9 was in bed, alert, oriented and verbally responsive. R9 was clean and without odor. R9 stated that either on 6/21 or 6/28 (a Monday) she requested one of the staff (does not remember who) to warm up the water that she has inside her white disposable cup because it was cold for her tea. According to R9 when the staff came back with the hot water, the staff offered to transfer the hot water into her (R9) insulated water container. R9 stated that she told the staff that she will transfer it herself because her insulated water container still has some water in it, and she does not want it mixed. R9 stated that she told the staff to place the disposable cup with hot water on top of her over bed table. R9 stated that she waited at least more than 30 minutes and when she was ready to transfer the hot water into her insulated cup, she moved her over bed table towards her and placed the said over bed table directly on top of her abdominal area. As she was attempting to transfer her hot water from the disposable white cup into her empty insulated cup, the over bed table moved that caused the hot water to spill on her, saturating her blankets and hospital gown. R9 stated that she started screaming and V6 (CNA/Certified Nursing Assistant) came in her room and saw what had happened. R9 stated that V6 immediately called V7 (Infection Control Nurse) who came in her room and assessed her. According to R9 she sustained burns on her stomach area, and on both her left and right thighs. R9 stated that V7 immediately applied cold towels on her abdominal area and on her thighs and both V6 and V7 changed her hospital	S9999		

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S9999	Continued From page 3 gown and beddings. R9 stated that sometime in the afternoon of that same day (6/21 or 6/28/21) V5 (Wound Care Nurse) applied an ointment/cream (does not know what type) on her abdominal area and thighs. According to R9, the burn on her abdominal area had healed, but the burn on her thighs are still present and is giving her pain when the dressing is not present because the area gets wet from her urine. R9 stated that she does not receive the treatment on her burn areas consistently. According to R9 if V5 is not working, no treatments are applied to her wounds. On 7/21/21 at 10:04 AM with V5 (Wound Care Nurse), V7 (Infection Control Nurse) and V8 (Wound Care Nurse in Training), R9 agreed to show the condition of the burn areas in her abdomen and thighs. R9's abdominal area had no redness, no open wound, no blister and/or any scar formation. V5 stated that the blister sustained from the burn on R9's abdominal area had healed (does not remember when). R9's left thigh was observed with a slightly discolored dressing (yellowish) in place. After V5 removed the dressing, a small wound without drainage or odor was noted. According to V5, when the burn incident happened R9 sustained two blisters on her left thigh and one of the blisters is already healed leaving only the site that had the dressing. R9's right thigh was observed with two small wounds without drainage or odor. These two wounds had no dressing in place. R9 stated that the dressing on her right thigh came off on 7/20/21 and that V9 (CNA) was aware of it. R9 stated that no one did the treatment on her thighs on 7/20/21. According to V5 when the burn incident happened, R9 sustained two blisters on her right thigh.	S9999		

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S9999	Continued From page 4 R9's progress notes dated 6/21/21 (9:05 AM) shows, "Resident explained she had 'spilled hot water on herself when moving her tray table.' Upon examination, abdomen and inner (right) and (left) thighs were red. Cold wet compress were applied to area. Wound nurse consulted for further examination and possible treatment." R9's weekly skin alteration review dated 6/21/21 (12:23 PM) created by V5, shows that redness measuring 13.5 cm (centimeters) x 11 cm was measured on the resident's abdominal area with a blister measuring 1.4 cm x 1.5 cm. No drainage and no pain documented. The same skin alteration report indicated "Current treatment orders - Silvadene ointment." R9's weekly alteration review dated 6/21/21 (12:41 PM) created by V5, shows that the resident had a blister measuring 2 cm x 3 cm on the right front thigh. No drainage and no pain documented. The same skin alteration report indicated "Current treatment orders - Silvadene." R9's weekly skin alteration review dated 6/21/21 (12:45 PM) created by V5, shows that the resident had a blister on the left front thigh, but no measurement was documented. There was also no documentation of drainage or pain. The same skin alteration report indicated "Current treatment orders - Silvadene." R9's physician order report for the month of June 2021 and the TAR (Treatment Administration Report) for the months of June and July 2021 shows no documentation of the Silvadene treatment order and there was no documentation that the Silvadene treatment was applied to R9's abdominal area, and bilateral thighs from 6/21/21 through 7/5/21.	S9999		

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S9999	Continued From page 5 R9's order summary report shows an order dated 7/6/21 for "wound- abdomen/upper thighs, clean with NSS (Normal Saline Solution) pat dry. Apply Silvadene daily until healed, one time a day for burn." This treatment order was scheduled to be administered at 8:00 AM. Review of R9's TAR for the month of July 2021 starting 7/6/21 shows no documentation that the Silvadene treatment order to the abdomen and thighs were applied as ordered on 7/10, 7/11, 7/17, 7/18 and 7/20/21. On 7/21/21 at 12:00 noon, V5 stated that when she saw the burn wounds of R9's abdomen and bilateral thighs on the afternoon of 6/21/21, she called the primary physician's office and got the order to treat the burn sites with Silvadene as documented on R9's weekly skin alteration review dated 6/21/21. V5 stated that about 2 days after the liquid burn incident, all of R9's blisters (abdomen and bilateral thighs) "popped." According to V5, based on her review of R9's weekly skin alteration sheet dated 7/16/21, the one popped blister on the left thigh became two separate open wounds located on the resident's left inner upper thigh and left inner lower thigh, and the one popped blister on the right thigh also became two separate open wounds located on the resident's right inner upper thigh and right lower thigh. V5 was asked why there was no documentation that the ordered Silvadene treatment was applied to R9's abdominal and bilateral wounds from 6/21/21 through 7/5/21. V5 responded that she forgot to place the Silvadene treatment order in the electronic order record and because of that no treatment administration record was generated for the nurses document treatments. During the same interview V5 stated	S9999		

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S9999	Continued From page 6 that on 7/10, 7/11, 7/17, 7/18 and 7/20/21 she was not working and during those days no one provided treatment on R9's wounds as ordered. On 7/21/21 at 12:30 PM, V2 (Director of Nursing) stated that if the Silvadene treatment order was not transcribed in the electronic order record, the TAR will not reflect the treatment order to apply the Silvadene to R9's abdomen and bilateral thighs. V2 stated that if there was no documentation on the TAR that the Silvadene treatment were applied, the ordered treatments were not administered. R9's progress notes dated 7/9/21 shows, "Liquid burn wound to abdomen resolved. Skin intact." R9's weekly skin alteration review dated 7/16/21 shows that the resident has two open wounds on the left thigh. The left thigh wounds were documented as, "left inner lower thigh," measuring 0.3 cm x 0.7 cm x 0.1 cm with small serous drainage, with pain during treatment, rated at 3 (0-10) and the "current treatment orders - Silvadene" and "left inner upper thigh-liquid burn open blister," measuring 0.5 cm x 1 cm x 0.1 cm with small amount of serous drainage with pain during treatment, rated at 3 (0-10) and the "current treatment orders - Silvadene." Further review of R9's weekly skin alteration review dated 7/16/21 shows that the resident has two open wounds on the right thigh. The right thigh wounds were documented as: "Right inner thigh upper-liquid burn" measuring 0.5 cm x 3 cm x 0.1 cm with small amount of serous drainage with pain during treatment, rated at 3 (0-10) and the "current treatment orders - Silvadene" and "Right lower thigh," measuring 2 cm x 1 cm x 0.1 cm with small amount of serous drainage with pain during treatment, rated at 3 (0-10) and the	S9999		

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S9999	Continued From page 7 "current treatment orders- "Silvadene." R9's progress notes dated 7/21/21 shows, "Liquid burn to the left lower thigh resolved, skin intact, discoloration to the area surrounding the lower part of the thigh." R9's weekly skin alteration review dated 7/21/21 shows that the resident's "left upper inner thigh-liquid burn" measured 2.5 cm x 0.5 cm x 0.1 cm with small amount of serous drainage with pain during treatment as manifested by resident moaning. R9's left upper inner thigh wound had increased in size compared to the 7/16/21 assessment. Further review of R9's weekly skin alteration review dated 7/21/21 shows that the resident's "right inner upper thigh - liquid burn" measured 1.7 cm x 1.7 cm x 0.1 cm with small amount of serous drainage with pain during treatment as manifested by resident moaning, and the "right lower inner thigh- liquid burn" measured 0.4 cm x 0.7 cm x 0.1 cm with small amount of serous drainage with pain during treatment as manifested by resident moaning. Review of the facility policy and procedure regarding administration of medications with current issue date of 1/1/2020 shows in-part, "11. Topical medications used in treatments shall be recorded on the resident's treatment record." On 7/22/21 at 3:00 PM, V18 (Nurse Practitioner) stated that if an order was obtained to treat R9's burn wounds with Silvadene, the treatment order should be followed because if the treatment order was not administered, there will be a delay in the healing process of the wounds. V18 added that if the Silvadene treatment was applied, it should be documented in the resident's record based on the facility policy.	S9999		

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S9999	Continued From page 8 (B) (Violation 2 of 2) 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. 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: 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	S9999		

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S9999	Continued From page 9	S9999		

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 interview and record review, the facility failed to supervise a resident identified as high risk for fall according to the plan of care. This applies to 1 of 3 residents (R1) reviewed for fall in the sample of 11. This failure resulted in R1's unwitnessed fall with injury requiring hospitalization.

Findings include:

R1 was admitted to the facility on 6/27/21 with multiple diagnoses which included dementia without behavior disturbance, anxiety disorder, atherosclerotic heart disease without angina pectoris, hypertensive heart disease with heart failure, polyosteoarthritis, history of TIA (transient ischemic attack) and cerebral infarction without residual deficits, and history of falling, based on the face sheet.

R1's admission MDS (Minimum Data Set) dated 7/7/21 shows that the resident is severely impaired with cognition and would require limited assistance with most of her ADL (Activities of Daily Living) including bed mobility, transfer, dressing, toilet use and personal hygiene.

R1's fall risk review dated 6/27/21 shows that the

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S9999	Continued From page 10 resident is a high fall risk. R1's progress notes dated 6/30/21 (2:40 AM) shows that the nurse heard the resident crying from her room. R1 was found on the floor beside her bed. "The resident verbalized that she was trying to go to the bathroom when she fell." R1 was assessed by the nurse and was found to have a hematoma on the left side of her forehead. R1 was assisted back to bed and an ice pack was applied to the hematoma. R1 was taken to the hospital for evaluation. The resident returned to the facility from the hospital that same day (6/30/21). R1's fall incident report dated 6/30/21 (2:40 AM) shows that the resident had an unwitnessed fall related to unassisted self-transfer from bed. This incident report shows predisposing physiological factors of the fall identified by the facility to include, confusion and gait imbalance. R1's fall risk review was updated by the facility on 6/30/21 post fall incident, which indicated that the resident remained a high fall risk. R1's care plan initiated on 6/28/21 indicated that the resident is at risk for injury related to falls secondary to history of falls, cognitive impairment, unsteadiness on feet, lack of coordination, history of TIA and cerebral infarction. The same fall care plan shows that new interventions were initiated on 6/30/21 (post fall) which included, "Observed frequently and placed in supervised area when out of bed." R1's progress notes dated 7/9/21 (7:52 PM) created by V13 (LPN/Licensed Practical Nurse) shows, "6:55 pm Nurse walking past resident's room, observed resident on floor by (wheelchair)	S9999		

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with large wound on left dorsal hand, moderate bleeding noted. Left arm elevated, pressure dressing applied, 911 called for transport. 7:00 pm Resident's daughter informed of fall and injury and transfer to ER (emergency room). (Physician) informed of fall and injury."

R1's incident report dated 7/9/21 shows that the resident had an unwitnessed fall in her room. The report shows in-part, "Nurse walking by resident's room, saw resident on floor, her (wheelchair) behind her on the door, noticed large wound to left hand. Resident does not know how or why she fell." This incident report shows predisposing physiological factors of the fall identified by the facility to include, resident's confusion, incontinence, impulsiveness, gait imbalance, impaired memory and decreased safety awareness and decreased strength/ endurance.

R1's emergency department physician report dated 7/9/21 shows that the resident sustained a V-shaped laceration on the left hand, approximately 10 cm (centimeters) in total length with mild active bleeding. The subcutaneous tissue was exposed but no bone exposure or tendon exposure. A total of 10 simple interrupted sutures were placed. The emergency department physician report also shows, "The first digit at IP (interphalangeal) joint appear retracted, possibly dislocated. With application of manual pressure to joint, remainder of digit extends into anatomic appearing position, however, retracts again upon release and does not stay in anatomic position."

On 7/19/21 at 11:22 AM, V19 (CNA/Certified Nursing Assistant) stated that she was the assigned staff for R1 on 7/9/21 from 2:00 PM through 10:00 PM. V19 stated that R1 had dinner inside the second-floor dining room between 5:00

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S9999	Continued From page 12 PM and 5:30 PM. According to V19 on 7/9/21 at around 6:20 PM she informed V13 (LPN/Licensed Practical Nurse) that she was going to the first floor to get more linens. V19 stated that before going back to the second-floor unit she also went to use the restroom. According to V19 when she left the second-floor unit, R1 was still inside the dining room and when she came back, R1 already had a fall inside her room. V19 stated that when she saw R1 on the floor inside her room, V13 was already checking the resident. V19 does not know who took R1 from the dining room to her room. According to V19, R1 was confused but was able to wheel herself to go to the dining room and back to her room. V19 stated that she was aware that R1 was high risk for fall and needs to be in a visible area when she is not in bed, which is why before she left the second floor unit to go the first floor she informed V13 to keep an eye on the residents inside the dining room, including R1. On 7/19/21 at 11:45 AM, V13 stated that on 7/9/21 sometime after dinner (does not remember exact time), V19 informed her that she (V19) will go to the first floor to get more linens. V13 stated that because V19 left the unit, "I was monitoring the dining room because I know that (R1) was inside the dining room with other residents and I know that she can wheel her chair on her own." According to V13 she was aware that R1 was high risk for fall which is why she was monitoring the dining room until V19 comes back, but she got distracted. V13 was asked why she got distracted and V13 responded, "I am not sure; probably another resident asking for her medication." According to V13 the other resident who asked for her medication was not in any pain or in any distress. V13 stated that because of the distraction she did not notice that R1 had wheeled	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004766	A. BUILDING: _____ B. WING _____	C 07/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC JOLIET	222 NORTH HAMMES JOLIET, IL 60435

(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
S9999	Continued From page 13	S9999		

herself out of the dining room to her room. V13 stated that at around 6:55 PM on 7/9/21 while walking past R1's room she noticed the resident on the floor inside her room approximately 3-4 steps away from the door, with her face and both hands down on the floor and her wheelchair behind her. V13 stated that while R1 was on the floor she noticed that blood was coming out from the resident's left hand. According to V13 she immediately called for staff assistance and another nurse (V20) came and helped with assessing R1 and putting the resident back to her wheelchair. V13 stated that pressure was applied on R1's left hand, 911 was called and while waiting for the EMS (Emergency Medical Service) personnel to arrive, R1 was placed by the nursing station for close monitoring. According to V13, R1's physician and daughter were informed of the fall and injury.

On 7/26/21 at 3:29 PM, V3 (Assistant Director of Nursing) measured the distance from the second floor dining room to the room where R1 was found on the floor, using a measuring wheel. The distance was measured as 60 feet.

On 7/19/21 at 12:15 PM, V21 (Nurse Practitioner) stated that she saw R1 once at the facility on 7/7/21 because the resident was a new patient. V21 stated that she saw R1 at the dining room with fading bruises on the left side of her face which according to the staff was from her previous fall at the facility. V21 was asked about R1's progress notes dated 7/7/21 which she documented, "Unsteady gait. Maintain fall precautions all the time." V21 responded that it is standard to document fall precaution on the resident's record especially since R1 had history of fall prior to admission to the facility and another fall while at the facility, and because R1 was

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S9999	Continued From page 14 confused due to dementia. V21 was aware that R1 was sent to the hospital on 7/9/21 after another fall with injury at the facility. V21 was informed that post fall on 6/30/21, the facility added an intervention to place R1 in supervised areas when out of bed. V21 stated that the mentioned intervention is part of the facility's fall precaution plan and should be followed to prevent R1's fall and injury. (B)	S9999		