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 _____	R-C 08/30/2021

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PARC JOLIET	222 NORTH HAMMES JOLIET, IL 60435

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S 000	Initial Comments First Complaint Certification Revisit to survey date 7-26-2021, Complaint 2174821/IL135807, 2175097/IL136160	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210d)2) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

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 provide dressing changes to wounds per physician orders. This applies to 3 of 3 residents (R3, R90, R96) reviewed for wound treatments in a sample of 20.

This failure resulted in delayed healing of wounds for R3, R90 and R96.

Findings include:

1. R90's Admission Notes dated 4/28/21 document R90 admitted to the facility post partial left foot amputation and status post stump infection. R90's Weekly Skin Alteration dated 4/29/21 documents R90's left lateral foot wound as measuring 2 X 5.5 X unmeasurable

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S9999	Continued From page 2 centimeters (cm) at admission. On 8/23/21 at 11:10 AM R90 stated he had the toes on his left foot amputated in February 2021 and the incision on the side of his left foot has never fully healed. R90 stated his dressing to his left foot does not get changed on weekends. R90 stated he wants it to heal so he can walk on it again. R90 reported the dressing was not changed for 5 days on one occasion and it has been infected since he has been admitted. R90 stated V5 (Wound Nurse) came in on 8/22/21 (Sunday) and changed his dressing this past weekend but it was not changed on 8/21/21 (Saturday). On 8/23/21 at 11:20 V5 and V4 (Wound Nurse) changed R90's dressing. R90 was observed with a linear open area to his lateral left foot which presented with no signs of infection. V4 stated R90's wound has been infected twice at the facility and he received antibiotics to treat the infections. Physician order dated 7/6/21 documents to cleanse R90's left lateral foot with normal saline, apply betadine and Santyl daily until healed. R90's July and August 2021 Treatment Administration Record (TAR) do not document R90's treatments were completed on July 10, 11, 17, 18, 20, 24, 31, 2021 and August 1, 2, 7, 8, and 21, 2021. R90's 6/22/21 Hospital Consult completed by V27 (Podiatrist) documents R90 with a worsening residual left lateral foot wound post metatarsal amputation measuring 5 X 7 X 0.4 centimeters requiring debridement. R90's Weekly Skin Alteration dated 7/2/21	S9999		

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S9999	Continued From page 3 documents R90's left lateral wound measuring 2.5 X 4.3 X 0.2 centimeters (cm). R90's Podiatry report dated 8/2/21, completed by V27, documents R90 with pain to left foot, postoperative transmetatarsal amputation 2/24/21 and post debridement. This report documents R1 reporting intermittent pain and when the dressing was removed to the lateral foot it had an odor with drainage present. This report documents R90's lateral foot wound measuring 3.2 X 0.6 X 0.3 cm. R90's Podiatry report dated 8/16/21, completed by V27, documents R90's lateral wound measuring 1.0 X 0.5 X 0.2 cm. R90's Physician Orders document R90 receiving Cefdinir 300 milligrams (mg) twice per day (BID) for 21 days beginning 6/26/21 and ending 7/16/21 for cellulitis of his left extremity. Also, R90's orders show Ciproflaxin 500 mg BID for 10 days beginning 7/24/21 and ending 8/3/21 for cellulitis of his left extremity. On 8/27/21 at 8:55 AM V27 (Podiatrist) stated, "(R90) reported they are not caring for his wounds as ordered by me. In this community this is a historically troubled facility. I am not comfortable with my residents receiving care there because I never know if they are receiving the proper care. His left lateral foot wound is a residual wound from his surgery after the toes were amputated. His foot was getting better after I debrided and re-vascularized the area, but healing has been intermittent and has slowed again. Lack of providing dressing changes as ordered is delaying his wound from fully healing. If he is not receiving the care as I ordered, it puts him at increased risk for infection, needing further	S9999		

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S9999	Continued From page 4 surgery and limb loss." R90's Brief Interview for Mental Status (BIMS) dated 7/2/21 documents R90 as cognitively intact. 2. On 8/23/21 at 11:30 AM R96 stated his dressings are not changed on weekends. R96 stated V5 (Wound Nurse) sometimes comes in on weekends and changes his dressing but no one changed the dressing on Saturday (8/21/21). On 8/23/21 at 11:35 AM V4 and V5 (Wound Nurses) completed a dressing change to R96's left 2nd toe. R96's left second toe had a yellowish dried scab covering most of the top of the left second toe. R96's Physician Order dated 6/9/21 document cleanse left second toe daily and apply Iodasorb. R96's July and August 2021 TAR do not document R96's treatments completed on July 10, 11, 17, 18, 20, 22, 24, 31, 2021 and August 1, 2, 7, 8, 14, 15 and 21, 2021. On 8/27/21 at 10:15 AM V28 (Podiatrist) stated R96 has a vascular wound to his left 2nd toe which tested positive for osteomyelitis and is localized to only the left second toe. V28 stated R96 needs to see a vascular surgeon before the toe is amputated in case it can be re-vascularized and saved. V28 stated every time the scab dries and falls off the bone is exposed. V28 stated R96's dressing should be changed every day. V28 further stated R96 has underlying vascular issues which contribute to his wound not healing properly, but the lack of dressing changes as ordered probably delays healing. R96's BIMS dated 7/7/21 documents R96 as	S9999		

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S9999	Continued From page 5 cognitively intact. 3. R3's Progress Note dated 6/21/21 documents R3 spilling hot water on herself inflicting a burn to her abdomen and both thighs. R3 stated her abdominal burn wounds have healed but she still has a wound to her left leg that is still being treated. R3 stated her treatments to the wounds are not done as ordered every day. R3's 8/2/21 Initial Wound Evaluation and Management Summary, completed by V29 (Wound Physician), documents R3 with a right upper thigh and left leg full thickness burn wounds. R3's 8/16/21 Wound Evaluation and Management Summary, completed by V29, documents R3's right thigh burn as resolved and the full thickness burn wound to her left leg remaining. On 8/24/21 at 11:15 AM an exam completed with V29 found R3's burn wounds to her abdomen, right upper thigh and left leg healed. R3's 7/6/21 Physician Orders document R3 with orders for Silvadene 1% apply to abdomen and bilateral leg/thigh wounds daily; this order was discontinued 7/21/21. R3's July 2021 TAR documents R3's treatments were not completed on July 10, 11, 17, 18, and 20, 2021. R3's 7/22/21 Physician Orders document R3 with orders for Silvadene 1% apply to bilateral leg/thigh wounds twice per day; this order was discontinued 8/4/21/21. R3's July 2021 TAR documents R3's treatments were not completed on the AM shift July 24 and 31, 2021 and the PM shift July 23-31, 2021. R3's August 2021 TAR documents R3's treatments were not completed	S9999		

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S9999	Continued From page 6 on the AM shift August 1, 2021 and on the PM shift August 1, 2 and 3, 2021. R3's 8/4/21 Physician Orders document R3 with orders for Silvadene 1% apply to left leg wounds daily; this order was discontinued 8/24/21. R3's August 2021 TAR documents R3's treatments were not completed on August 7, 8, 14, 15, 21 and 22, 2021. On 8/24/21 at 11:15 AM V29 stated she is aware wound treatments are not done consistently on weekends. V29 stated lack of consistent treatment and following orders delays healing and the wounds could have been healed sooner. R3's 7/29/21 BIMS documents R3 as cognitively intact. On 8/23/21 at 11AM V4 and V5 (Wound Nurses) stated the facility is so short they had issues with treatments getting done on the weekends so they made up treatment kits to make it easier for the nurses on weekends to get the treatments completed. Both confirmed on Mondays they come in and find left over untouched treatment kits from the weekends. The Facility Wound Policy dated 3/2021 documents the goals of healing wounds are to protect the ulcer from contamination and promote healing. (B) (Violation 2 of 2)	S9999		

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S9999	Continued From page 7 300.610a) 300.1210b) 300.1210c) 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 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.	S9999		

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S9999	Continued From page 8 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. (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 provide supervision and assistance to a residents with a change in status. The facility failed to provide assistance with Activities of Daily Living (ADL) care. The facility also failed to provide transfers to residents requiring one to two staff assistance using a proper transfer technique. This failure resulted in R113 being left in his room alone and falling and sustaining a laceration to his eye that required sutures. This failure also resulted in R96 incurring numerous falls when transfer assistance was not provided and R25 incurred an unsafe transfer. This applies to 3 of 4 residents (R113, R96 and R25) reviewed for falls in a sample of 131.	S9999		

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S9999	Continued From page 9 Findings include: 1. On 8/23/21 at 8:35 AM R113 was lying in his bed with resolving discoloration to outer left eye area. R113 could not indicate what happened. R113's Brief Interview for Mental Status (BIMS) dated 7/5/2021 documents R113 with severe cognitive impairments. The Facility Incident Report dated 8/11/21 at 4 PM documents V18 (Nurse) entered R113's room and he was in his bed with blood all over himself and on the floor by the bed. R113 was found with a laceration to the left temple which was documented as an unwitnessed injury. On 8/27/21 at 11:54 AM V18 (Nurse) stated R113 wheeled himself to the nurse's station naked three times and was acting more confused than his usual baseline. V18 stated R113 was saying, "Help me, help me." V18 asked R113 what he needed, and R113 said he didn't know. V18 sent R113 back to his room each of the three times and told him to put his clothes, and R113 returned to his room without staff assistance. V18 stated R113 was generally redirectable and this continued behavior in and out of his room was not normal. V18 stated he notified V23 (Nurse Practitioner), who arrived to the floor to assess R113's status change. When V23 and V18 went to R113's room to assess R113, V18 opened the door and found R113 on the bed with blood all over the bed and floor. V18 had a laceration to his temple area. V18 stated R113 must have tried to transfer himself from his wheelchair to bed and fell onto the floor then put himself back to bed. R113's 3/20/21 Fall Care Plan documents R113 is at risk for injury related to a falls due diagnoses including Schizophrenia, Peripheral Neuropathy,	S9999		

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and Deafness. R113 has decreased cognition and decreased mobility and functional ability. R113 requires staff assistance with his ADL needs including his transfers. R113's Fall Care Plan documents R113 has been noted to be crawling all over the floor from his bed and comes out of room naked. The interventions to prevent falls and injury include to redirect R113 when he is noted to be crawling on the floor or comes out of room naked and staff are to assist 113 to put on his clothes and back to his bed/ chair. R113 is an assist of 1 staff person for transfers.

On 8/23/21 at 12:20 PM V18 (Nurse) stated, "This (staffing shortage) is continuing to go on." V18 confirmed when staffing is short the staff cannot meet the needs of the residents.

On 8/24/2021 at 12:07 PM V2, (Director of Nursing) stated staffing for the 2nd floor where R113 resides between 2 PM - 10 PM should be 3 Nurses and 6 Nursing Assistants.

The corrected Daily Staffing Reports provided by V1 (Administrator) on 8/26/21 at 11:30 AM documents on 8/11/2021 between 2-10 PM there were 2 Nurses and 3 CNAs on the second floor.

On 8/27/21 at 12:07 PM, V25 (Nurse Practitioner) stated, "I would expect them to supervise and assist R113 back to the room to make sure he is safe, especially since he was more confused." V25 confirmed R113 requires assistance for transfers. V25 stated she was notified and sent R113 to be evaluated in the emergency room where R113 received 5 sutures to close the laceration.

R113's Emergency Room History and Physical dated 8/11/21 documents R113 with an

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S9999	Continued From page 11 unwitnessed fall and a head injury requiring sutures to close. 2. On 8/26/21 at 11 AM R96 sat in his wheelchair with a right above the knee amputation. R96 stated his balance isn't good because he only has one leg, and his left leg is weak and not always stable when he stands. R96 stated he doesn't ask staff for help because there isn't enough. He said they have told him to wait for help, but when he needs to use the bathroom he cannot wait as long as it takes to get staff assistance. R96 confirmed he has fallen a couple times recently toileting himself and staff had to assist him back into his chair. Facility Incident Report dated 8/20/21 at 1:49 AM, completed by V6 (Nurse) documents R96 was found on the bathroom floor without injury after self transferring from the toilet to the wheelchair. R96 reported his only leg became weak causing a fall. On 8/27/21 at 12:18 PM V6 (Nurse) stated she entered R96's room and the call light was on and she found R96 on the floor in the bathroom. V6 stated she did not know how long the call light was on before she responded. Facility Incident Report dated 8/22/21 at 5:10 AM, completed by V26 (Nurse) documents R96 was found on the bathroom floor without injury after self transferring to the toilet. R96 stated he was unable to grab the handrail properly and he fell. On 8/27/21 at 10:26 AM V26 stated R96 was found on the bathroom floor with his call light activated. V26 did not know how long R96's call light was on before he responded.	S9999		

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S9999	Continued From page 12 R96's Care Plan for falls dated 4/14/2017 documents R96 has a history of falls related to Multiple Sclerosis and right above the knee amputation. R96 is alert and is able to relay his needs to staff and will ask for assistance. R96 has decreased lower extremity strength, balance and endurance. Interventions include R96 is a one staff assist for transfers. The corrected Daily Staffing Reports provided by V1 (Administrator) on 8/11/21 at 11:30 AM documents staffing on the first floor where R96 resides on 8/20/2021 between 10 PM - 6 AM there was 2 Nurses and 1 CNA and on 8/22/21 1 nurse and 2 CNAs. On 8/24/2021 at 12:07 PM V2 (DON) stated staffing for the current census between 10 PM - 6 AM should be 2 Nurses and 3 Nursing Assistants. R96's BIMS dated 7/7/21 documents R96 as cognitively intact. 3. On 8/24/21 at 9:55 AM. R25 sat on the side of his bed with a contracted left arm and hand, and an above the knee amputation. V10 (Nursing Assistant) finished providing care to R25 and was transferring him from the bed to the wheelchair. V22 (Nurse) entered R25's room and asked V10 twice if she needed assistance transferring R25 and V10 declined both times. V10 grabbed the waistband of R25's pants and proceeded to transfer R25 from the bed to the wheelchair using his elastic waistband. R25 then asked to be repositioned in his chair and V10 again grabbed his waistband to straighten him in his wheelchair. R25's 11/7/21 Care Plan documents R25 at risk for falls and to utilize one person for transfers. R25's 7/30/2021 BIMS documents R25 as	S9999		

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PARC JOLIET	222 NORTH HAMMES JOLIET, IL 60435

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S9999	Continued From page 13 cognitively intact. On 8/26/21 at 11:30 AM V2 (DON) confirmed using the waistband of residents pants for transfers is not a safe transfer technique. The facility policy Activities of Daily Living 9.2020 documents to transfer residents using a gait belt. (B)	S9999		