

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2022
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NAME OF PROVIDER OR SUPPLIER OUR LADY OF ANGELS RET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 WYOMING AVENUE JOLIET, IL 60435
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(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	S 000		
	Facility Reported Incident of August 4, 2022			
S9999	Final Observations	S9999		
	<p>Statement of Licensure Violations:</p> <p>300.610 a) 300.1210 b) 300.1210 d)6)</p> <p>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.</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the</p>			
			Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to use available safety devices to prevent falls for two residents (R1 and R2) in the sample of 4 residents reviewed for falls.</p> <p>This failure resulted in R1 sustaining a sub-arachnoid hemorrhage from a fall from the wheelchair when R1 was being transported in a wheelchair without foot rests. This failure also resulted in R2 sustaining a laceration and sutures after a fall in the bathroom when a gait belt was not used during transfer.</p> <p>Findings include:</p> <p>1. According to the facility record, R1 is 90 years old and has resided in the facility since 6/23/21. The record shows R1 has diagnoses including but not limited to generalized muscle weakness and a history of falling.</p> <p>According to the facility EMR (Electronic Medical Record), the 3 most recent fall assessments for R1, dated 9/16/21, 6/27/22, and 8/7/22, each show R1 to be at High Risk for Falling.</p> <p>On 8/5/22, the facility reported R1 fell from a wheelchair as it was propelled by activities staff.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>The report shows R1 sustained a sub-arachnoid hemorrhage in the fall.</p> <p>The fall investigation provided by the facility showed the wheelchair in which R1 was propelled had no foot rests attached, and the resident's "foot got caught on the rug and she fell out of the chair."</p> <p>The hospital record shows R1 did sustain a subarachnoid hemorrhage. R1 was released back to the facility on 8/6/22.</p> <p>On 8/16/22 at 3:24pm, V8 (Activities Aide) stated she was pushing R1 in her wheelchair to activities when she seemed to get her foot caught on the carpet and she tumbled from the wheelchair. V8 stated there were no foot/leg rests on the wheelchair at the time, although she believes there are leg rests for the wheelchair somewhere.</p> <p>On 8/15/22 at 11:40am, V5 (Therapy Director) stated, "We do recommend that staff do put leg rests on when propelling a resident even if they can propel themselves." V5 stated this was discussed in the Interdisciplinary Team meeting regarding R1 after her fall. V5 stated it's a safety issue.</p> <p>On 8/16/22 at 1:40pm, V4 (Medical Assistant) stated she would expect the facility personnel to use the foot rests on the wheelchair, as a matter of safety.</p> <p>On 8/16/22 at 2:42pm, V9 (Medical Doctor) stated the staff should use foot rests when R1 is propelled from behind, given her needs, as they should with anyone being pushed. V9 stated, "I sent her to the hospital to make sure there was no internal bleeding".</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On 8/16/22 at 1:21pm, V2 (Director of Nurses) stated R1's wheelchair should have foot rests.</p> <p>On 8/16/22 at 3:24pm, V8 stated she didn't remember being told about using foot rests before R1 fell, but "Today we were told everyone should have foot rests when being propelled."</p> <p>On 8/16/22 at 9:56am, V3 (Activities Aide) was pushing R4 in a wheelchair through the hall without leg/foot rests. V3 stated she was not aware of an in-service being done regarding wheelchair foot rests.</p> <p>2. According to the facility record, R2 is 91 years old and has resided in the facility since 11/5/20. The same record shows R2 has diagnoses of generalized weakness, unsteady on feet, difficulty walking, Parkinson disease, and history of falling.</p> <p>According to the fall investigation provided by the facility, on 6/7/22 at 8:45pm, R2 was assisted in transferring from the commode when R2 fell. The same report shows the Nurse was called and found R2 sitting on the bathroom floor with her back to the bathtub, bleeding from a laceration to the back of her head. R2 was subsequently transported to the hospital where R2 needed 7 staples to close the wound. The same report does not refer to the use of a gait belt to assist the transfer.</p> <p>On 8/15/22 at 4:04pm, V6 (CNA) stated she was assisting R2 on 6/6/22 when R2 stood, holding the sink, then fell backwards. V6 stated there was no room in the bathroom to stand in front of R2, so the method is to have her hold on to the sink. V6 stated she was not using a gait belt at that time. V6 stated she had asked to have a</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>bed-side commode placed in R2's room to provide for more room to assist, but that had not happened by that time.</p> <p>On 8/16/22 at 2:05pm, V10 (Medical Doctor) stated, "I would expect the staff to use a gait belt for R2 given her needs and the very close quarters in the bathroom."</p> <p>On 8/16/22 at 1:21pm, V2 (Director of Nurses) stated R2 should have had a gait belt on during any transfer.</p> <p>The facility provided a Policy, entitled Use of Gait Belt Policy, undated, showing: "Policy: It is the policy of this Center to use gait belts, for the purpose of safety, with residents who cannot independently ambulate or transfer."</p> <p>(A)</p>	S9999		