TIM IOS L	Jepai unent di Fublic	nealth		Table 1	Sales Contract and in the	4 4 196 FAMILY AV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	IL6011910		B. WING_		C 06/30/2022		
NAMEOF	PROVIDER OR SUPPLIER	STREET A	ODRESS CITY	, STATE, ZIP CODE		OULULL	
OT 04-	10//0 220021		OOKDALE				
CRISTON OF	RICK'S RESIDENCE	NAPERV	ILLE, IL 60				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		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				
	Complaint Investiga	tion: 2274861/IL148225					
S9999	Final Observations	en N	S9999	2			
5	Statement of Licens 300.610 a)	ure Violations:		2 2			
	300.1210 b)4)5) 300.1210 c) 300.1210 d)6)					3	
	procedures governir facility. The written per formulated by a F Committee consisting administrator, the admedical advisory corror for formulated and other policies shall comply the written policies state facility and shall leave to the facility and shall	nave written policies and and all services provided by the policies and procedures shall Resident Care Policy g of at least the livisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. Shall be followed in operating the reviewed at least annually ocumented by written, signed				12 20 0	
	Nursing and Persona b) The facility shall properties to attain practicable physical, well-being of the resident's complan. Adequate and procare and personal caresident to meet the training personal personal care needs of the resident to must personal personal care needs of the resident to must personal care needs of the resident personal care needs	rovide the necessary care or maintain the highest mental, and psychological dent, in accordance with prehensive resident care properly supervised nursing re shall be provided to each total nursing and personal		Attachment A Statement of Licensure Violations			

Ilinois Department of Public Health

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

TITLE

(X6) DATE

	Department of Fublic					4 74 997	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011910		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			C 06/30/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY.	STATE, ZIP CODE	1 00	13012022	
ST PATI	RICK'S RESIDENCE		OKDALE R				
		The state of the s	LLE, IL 605	63			
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I ID RE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 1	S9999				
	circumstances of the demonstrate that dir This includes the re- dress, and groom; to eat; and use speech	iving do not diminish unless e individual's clinical condition minution was unavoidable. sident's abilities to bathe, ransfer and ambulate; toilet; a, language, or other	<i>a</i> .		Œ		
99	functional communication who is unable to car shall receive the ser good nutrition, groor 5) All nursing pencourage residents transfer activities as effort to help them re-	cation systems. A resident ry out activities of daily living vices necessary to maintain ning, and personal hygiene. Personnel shall assist and with ambulation and safe often as necessary in an etain or maintain their highest	(TR)		12.		
e ²⁷	c) Each direct care- be knowledgeable al respective resident of	giving staff shall review and bout his or her residents'			<u> </u>		
a a	care shall include, at and shall be practice seven-day-a-week ba 6) All necessary to assure that the res as free of accident ha nursing personnel sh	asis: precautions shall be taken sidents' environment remains azards as possible. All all evaluate residents to see					
ž.	and assistance to pre	ceives adequate supervision event accidents. T is not met as evidenced by:		£9. ∰ 35.			
	Based on record revious conservations, the facinesident from a whee This failure resulted in	ews, interviews, and lity failed to safely transfer a lchair to a standing scale. In R1 sustaining a left ankle to one of three residents					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C **B. WING** IL6011910 06/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 BROOKDALE ROAD ST PATRICK'S RESIDENCE NAPERVILLE, IL 60563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 Findings include: R1's EHR (Electronic Health Record) showed that R1 was admitted to the facility on 5/19/22 after a hospitalization due to a fall. R1's Face Sheet showed her diagnoses include osteoarthritis of the knee, repeated falls, abnormalities of gait and mobility, weakness, severe morbid obesity, lymphedema, pain in left knee, and a right artificial knee joint. The Facility's fall Occurrence Report dated 6/7/22 showed that on 6/7/22, R1 was being weighed on a standing scale with only one person assisting her when her left leg gave out, causing an injury. R1 was sent to the local community hospital for evaluation. R1's progress note dated 6/7/22. showed that on 6/7/22 a CNA was attempting to weigh R1 when her left knee buckled, and her left knee and ankle rotated internally and R1 verbalized pain. R1 was then sent to the local emergency room hospital. R1's hospital records for date of service 6/7/22, showed she presented to the emergency room with left ankle pain and deformity after a fall. R1's x-rays revealed a fracture/dislocation at the tibiotalar articulation with anterior dislocation of the fibula. The x-ray also showed that there is a displaced fracture of the distal fibula with distal fracture fragments. The hospital records showed under Assessment/Plan that the hospital did a reduction to R1's dislocation and R1 was placed on restrictions of NPO (Nothing by Mouth) as she awaits a consultation from an orthopedic doctor regarding possible surgery. On 6/29/22 at 9:38am, V11 CNA (Certified Nurse's Assistant) said that on 6/7/22 she was assigned to R1, and she was transferring R1 from

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED C IL6011910 B. WING 06/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 BROOKDALE ROAD ST PATRICK'S RESIDENCE NAPERVILLE, IL 60563 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 3 S9999 her wheelchair to a standing scale when R1 became weak and fell on the base of the standing scale. V11 said that R1 ambulated with a wheelchair but felt that she could step up and stand on the scale with her assistance. V11 said that this day was the first time she had been assigned to R1 and she thought R1 was a 1 person assist and she did not need to use a gait belt. V11 said that she was informed by the previous shift that R1 was a 1 person assist and she did not check R1's records to verify this. V11 said that when R1 was getting on the scale, R1 out her left foot on the scale, then while lifting her right leg over the one-inch step, R1's left leg got weak and R1 began to fall. V11 said that she was the only person assisting R1 during this time. V11 said that there is a scale on another floor that is used to weigh residents that are in wheelchairs, but she thought R1 could stand on the scale by herself with her assistance. On 6/29/22 at 12:31pm V12 (Registered Nurse/RN) said that on 6/7/22 she was in a resident's room when she came out and saw V11 struggling with R1 on the standing scale. V12 stated she saw V11's arms around R1 as she was lowering her to the ground. V12 said that R1 ambulated with a wheelchair, and it is the facility's policy that if a resident is unable to stand then they are to be weighed in their wheelchair. On 6/28/22 at 12:32pm, V4 (Physical Therapist/PT) said that R1 is a 2 person assist. V4 said that on 6/7/22, R1 had just completed physical therapy, was tired/fatigued, had left knee weakness with pain, and because she was not weighed in her wheelchair or was assisted by two staff, it caused her to fall. V4 said that R1 had not yet received physical therapy for "stepping"

because she was not physically ready, and R1 linois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING IL6011910 06/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 BROOKDALE ROAD ST PATRICK'S RESIDENCE NAPERVILLE, IL 60563 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 should not have use the standing scale because it requires you to step up on to the scale. On 6/29/22 at 10:48am V8 R1's (Primary Care Physician) said that R1 ambulates with a wheelchair and if R1 had been weighed while still in the wheelchair, she would not have fallen. V8 also said there should have been 2 staff and a gait belt used because this would have prevented R1 from falling and causing her to sustain a fracture. V8 said that R1 was morbidly obese, and this contributed to her fall. On 6/28/22 at 2:29pm V7 (Director of Nursing) said that R1 should have been weighed in her wheelchair for safety reasons and if she had been weighed in her wheelchair she would not had fallen and sustained injuries. R1's care plan dated 5/20/22 showed that R1 had a deficit in ADLs (Activities in Daily Living) related to a fall on 5/18/22 with left knee pain. R1's care plan showed under Approach, the resident requires extensive assistance by 2 staff to move between surfaces and as necessary. R1's Physical Therapy Plan of Care with Start of Care 5/20/22 and End of Care 6/7/22 showed that R1 was admitted with a prior history of falls, and on 5/18/22 had another fall, and was hospitalized until 5/19/22 when she was admitted to the facility. The Plan of care showed that R1 had complaints of left knee pain, weakness, and decreased activity tolerance with resulting impairments in bed mobility, transfers and gait. The care plan showed that R1's medical history related to her condition included obesity and chronic lymphedema BLE (Bilateral Lower Extremities). R1's care plan showed that R1 used

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a wheelchair for mobility, and she needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:		(X3) DATE SURVEY COMPLETED C 06/30/2022	
		IL6011910	B. WING			
NAMEOF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		JUIZUZZ
ST PATR	RICK'S RESIDENCE	1400 BR	OOKDALE RO	DAD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID		000000000000000000000000000000000000000	
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S9999	Continued From pa	age 5	S9999			
	maximum assistan	ce with balance, and dynamic				
1	standing. Under Fu	unctional Deficits Section GG	1 1			Pag.
- 1	Mobility D. sit to sta	and R1's current level was			i ka	
	02-Substantial/max	timal assistance Helper does				-
	more than half the	effort. Helper lifts or holds		100	85 69	1
- 1	trunk or limbs and p	provides more than half the			10	E.
i	effort. R1's PT - Th	nerapist Progress & Discharge	19			
- 1	Summary Start date	e 5/20/22 and End date 6/7/22				S. 5=
J	snowed under secti	ion GG: Mobility, M 1 step				l.
	(curb), not attempte	ed due to medical condition or	1			
Ī	Therapist Aide) woo	nder 6/7/22 note: V5 (Physical te R1 was given verbal cues	1 1	925	*	
- 1	to increase her sten	height on her (RLE) right				
	lower extremity.	, noight of her (IVEE) fight		atr		
	The facility's Transfe	er policy (no date) showed				
	under Policy, it is the	e policy to reduce the risk of				
y.	injury to residents	. Procedure- 1. Evaluate the		Y ₂	1	
	situation. A. Identify	and obtain the equipment	l í	7	1	
- 1	and assistance need	ded.				45.
	The facility's Weighi	ing and Measuring the	1	88		
	resident policy dated	March 2011 showed under,		19		
	Preparation 1. Revie	ew the resident's care plan to				
3	assess for any speci	ial needs of the resident,				
	uncer, Equipment ar	nd Supplies - The following	1			
	equipinient and supp performing this proc	plies will be necessary when edure: 1. Appropriate Scale:				
	c. Platform scale (for	r non-ambulatory residents).	in in			
	8. To measure the no	on-ambulatory resident's	E OIL	0.00		
	weight using the plat	form scale; b. weigh the			42	
	wheelchairc. assis	st the resident into the				-
	wheelchair. D. Trans	port resident to platform			1.	
	scale. e. Roll the resi	ident onto the platform. Lock				
	he wheels.					
	he facility Gait Belt	Usage policy dated 1/1/2017				
	howed under Policy	To maximize safety for our				
	atients and staff we	require the use of a		22		
g	ait/transfer belt to be	e used while, lifting.	1		A CONTRACTOR	
	ransferring or ambul	letine mattents	51		1	

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING IL6011910 06/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 BROOKDALE ROAD ST PATRICK'S RESIDENCE NAPERVILLE, IL 60563 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 The facility's Fall - Clinical Protocol dated March 2018 showed under 3. The staff and practitioner will review each resident's risk factors for falling "A"