Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008957	A. BUILDING: ______ B. WING ______	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH VILLAGE OF CHICAGO	4021 WEST BELMONT CHICAGO, IL 60641

(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 Complaint Investigation: 2284349/IL147606	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 a)b)c) Section 300.690 - Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

summary of each reportable accident or incident to the Department within seven days after the occurrence.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to document descriptive summary of fall incidents, and report incident to State Agency per regulatory requirement of 1 out of 4 residents reviewed for incidents and accidents. These failures impede accurate determination of fall incidents related to R1.

Findings include:

On 6/30/2022 at 9:27 AM. V2 (Daughter of R1) stated that the incident that happened on 5/29/2022 was at rehab, V3 (Daughter of R1) her sister was present. When R1 slipped on the floor and hit his head on the foot board. R1 has history of craniotomy procedure last April. V2 also stated that facility is doing a good job but has problem with lack of staffing. At 10:20 AM, R1 was seen in the dining room on a wheelchair by himself. After conversation with R1, facility staff transferred R1 near the nurse's station. R1 has amputation on his right arm was alert and verbally responsive. R1 unable to remember the name of his current place. But was able to remember the names of V2 and V3 and the time but not the month. R1 cannot remember the incident when he fell when asked.

6/30/2022 at 11:30 AM, V8 (Director of Clinical Services) stated that it was the daughter of R1 who informed nurse on duty V9 (Registered Nurse) that R1 was on the floor. Because of that

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S9999	Continued From page 2 fall R1 had a laceration at the back of his head. R1 was sent to ER and CT scan was performed. R1 came back to the facility after few hours. R1 needs extensive assistance due to cognitive impairment. No, I did not spoke to V3 (R1's Daughter). I tried calling her but did not get any answer. V2 left the conference room and returned after few minutes. V2 then stated, it was V2 (R1's Daughter) who witnessed the fall. According to V9, R1 hit his head on the wheelchair. Per V9 notes it was V2 not V3 that was with R1 that night. I understand, if I called V2 to verify what happened I will be able to make sure if it was V2 or V3 that was with the R1. Yes, there was a fall before 5/29/2022 it happened on 5/28/2022. The fall on 5/28/2022 was not documented on the progress or nurse's notes because we do it internally. Internally means, we have procedure that only authorized staff can access. I was not aware that incidents and accidents need to be documented on the progress or nurse's notes. But I agree that it makes sense to document it in the progress notes. R1 can get up for less than 3 seconds. I understand that R1 needs extensive assistance and care plan as to use gait belt when ambulating and needs frequent monitoring. We monitor him every 2 hours. And staff still needs to monitor resident even when they have visitor with them. As to V9 we have a hard time getting her contact number. I called the agency and was told that they first need V9 approval before giving her contact information. I know it seems not right when V9 takes care of residents in the facility. But we cannot access her with calling if needed to contact her. In the past R1 has CT because he has craniotomy procedure done and follow up appointment were set that includes CT scan. Per family R1 has multiple falls at home before coming in the facility. Yes, our fall prevention policy was taken directly from a nursing author.	S9999		

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We follow what is written on that procedure. I did not report the incident to State Agency because I was doubtful if it needs to be reported after I knew the CT scan was negative.

Record Review

R1 was 83 years old, initial admission date 4/18/2022. R1 medical diagnosis includes dementia, traumatic subdural hemorrhage with loss of consciousness, Parkinson's disease, muscle weakness, unsteadiness of feet and history of falling. R1 Minimum Data Set (MDS) assessment dated 4/25/2022 are as follows: Brief interview for mental status (BIMS) has a score of 6. That means R1 has cognitive impairment. Functional Status are as follows: For transfers, R1 needs 2-persons extensive assist. For walk in room or corridor, R1 needs 1-person extensive assist. Extensive assistance means resident involved in activity. Staff provide weight-bearing support. For balance during transitions and walking related to moving from seated to standing position, walking, turning around and surface-to-surface transfer not steady, only able to stabilize with staff. R1 uses walker and wheelchair as mobility devices. R1's care plan documents that R1 has chronic fall with intervention for 2-persons assist for transfer using a gait belt, 1-person extensive assist during walking and extensive assist using walker during locomotion. Fall risk level at risk. Follow facility fall protocol. R1's Progress Notes dated 5/29/2022 at 10:17 PM documented by V9 (Registered Nurse) reads: Daughter verbalized that her father (R1) was trying to get up from his wheelchair and fell. Laceration at the back of R1's head. R1 was sent to ER for further evaluation.

R1 has 3 fall incidents that are as follows:

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S9999	Continued From page 4 5/28/2022 Unwitnessed Fall. No documentation found in the progress or nurse's notes. 5/29/2022 Witnessed Fall. Per progress notes, R1 sustained an abrasion at the back of his head was sent to ER for further evaluation. CT scan was done no significant finding. V8 (Director of Nursing) stated that facility was unable to get written documentation of CT scan result from the hospital. 6/9/2022 Unwitnessed Fall. Per progress notes, R1 was found on the floor on the hallway just outside the nurse's station with his wheelchair folded beside him. No injury noted. R1's fall assessments with the following dates 4/18/2022, 5/28/2022, 5/29/2022 and 6/9/2022 at documents that R1 were at high risk for falling. Per facility adopted policy on fall prevention, long-term care with review date 2/17/2022: After the fall, complete a detailed report to help track frequent resident falls so that your facility can implement preventive measures for high-risk residents. In the incident report, note where and when the fall occurred, how you found the resident, and in what position. Include the event that preceded the fall, the names of witnesses, the resident's reaction to the fall, and a detailed description of the resident's condition based on assessment findings. (C)	S9999		