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
	IL6004550	A. BUILDING: ______ B. WING ______	C 10/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY FAMILY VILLA	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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S 000	Initial Comments Complaint Investigation 1896194/IL105942 Statement of Licensure Findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
11/02/18

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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,

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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.

These Regulations were not met as evidence by:

Based on interview and record review, the facility failed to follow the facility's policies on fall prevention and incontinence and failed to implement the fall risk interventions and failed to follow the interventions for toileting checks for 1 of 3 residents (R1) reviewed for fall prevention interventions.

This failure lead to R1 getting out of bed attempting to use bathroom subsequently falling and sustaining a laceration to the top of the head that required 10 staples and 2 units of blood.

The findings include:

R1 is a 91 year old, non-ambulatory female who was admitted to the facility on 7/3/18 for short term rehabilitation services due to R1's repeated falls in the assisted living residence per the 7/9/18 (initial) and 7/16/18 (14 day) Minimum Data Set (MDS). R1's diagnoses include altered mental status, hypertension, Alzheimer's dementia, anxiety, depression and repeated falls. R1 has a

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brief interview mental score (BIMS) of "3" and required extensive assistance with transfers, dressing, hygiene and bathing. R1 was occasionally incontinent of bowel and bladder per both MDSs.

During R1's stay in the facility from 7/3/18 to 7/22/18, R1 sustained a total of 3 falls per the facility's fall investigations. The first fall was on 7/5/18 at 2:45 AM in the lounge area at the nurses' station of 2 North. R1 was sleeping in a recliner chair when R1 awoke leaned forward and slid out of R1's chair. The certified nurse aide (CNA) that witnessed the fall was unable to get to R1. R1 sustained a hematoma on the left side of the head and was sent to the hospital. R1 returned with diagnoses of small left frontal scalp hematoma which resulted in facial bruising from the fall. The second fall was on 7/7/18 at 1 AM where R1 rolled out of the low bed onto the floor mat. After this fall, a perimeter mattress was implemented. The third fall was on 7/22/18 at 12:45 AM in R1's room where R1 was heard yelling "help, help." V5 (assigned CNA) and V10 (Agency Licensed Practical Nurse/L.P.N.) who were at the nurses' station, went to R1's room and found R1 on the floor mat next to the bed with large amounts of blood on the floor and floor mat. It was noted that R1 was bleeding from the laceration on R1's left upper side of head. R1 was alert but confused and could not say what happened. 911 was called after pressure was applied to R1's head. All appropriate parties were notified. R1 was sent to the hospital.

After the first fall on 7/5/18, the facility staff did an extensive investigation which included information from family about R1's habits at home. It was determined to change the medications times for Detrol which is used for

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urgency and frequency of urination from morning to bed-time and the medication Ativan (anti-anxiety) was changed to bed-time along with the implementation of Melatonin. Another intervention was doing a post void residual after each voiding for a 24 hour period.

The Bowel and Bladder Elimination Pattern Assessment which is used to determine the elimination patterns for 72 hours is dated 7/16/18 and documents that the voiding was tracked on 7/10/18, 7/11/18, 7/12/18. From this assessment, and the Bowel and Bladder Program Summary dated 7/16/18 documents R1 being incontinent at 4 PM, 7 PM, 10 PM and midnight.

R1's July 2018 Plan of Care Flow Sheet documents if resident is anxious, please offer/bring R1 to the toilet. R1 has a history of urinary frequency. On the bottom portion of this flow sheet, it documents 7/9/18: anticipate toileting needs. Bowel movements after lunch (1 hour after). R1 urinates frequently between 9 PM to 8 AM (3 times or more) - please offer.

R1's July 2018 Resident Toileting Schedule Flow Sheet documents to toilet resident before dinner between 3 PM to 4 PM, toilet after dinner between 6 PM to 7 PM, toilet before bed at 9 to 10 PM, anticipate toileting needs between 11:30 PM to 12 midnight, between 2 AM and 3 AM and between 5:30 AM to 6:30 AM. Toilet between 8 AM and 9 AM (after breakfast), toilet between 12:30 PM and 1:30 PM.

On 10/5/18 at 11:30 AM, V3 (Restorative Nurse) stated that R1 had not been in facility for 21 days (in facility for 19 days) and V3 had not done the detailed incontinence care plan. V3 stated there is an interim care plan that addresses R1 being

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incontinent of bowel and bladder and requiring total care. V3 stated that the CNAs are expected to follow the Resident Toileting Schedule Flow Sheet which was implemented due to R1's high risk for falls. V3 was shown the flow sheet which was lacking initials and signatures and V3 stated the CNAs should be signing it. V3 stated when she develops the detailed incontinence care plan, the interventions of scheduled toileting will be included.

The 7/3/18 and 7/5/18 nurses' note documents to closely monitor due to high fall risk. Nurses note dated 7/4/18 at 5 AM documents R1 was closely monitored due to 2 attempts to get out of bed through the night, incontinent of urine.

On 10/3/18 at 3:50 PM via phone, V5 stated that he, V10 and another agency CNA were all at the nurses' station when they heard R1 yelling "help, help" which V5 thought was around 11:30 PM. V5 stated that V10 and himself responded to R1's cries for help and found R1 on the floor mat next to the low bed with blood on the floor and on R1's head. V5 was asked about any special instructions for R1's toileting schedule. V5 stated this is the first time caring for R1 and he knew of no special instructions but planned on toileting R1 between 1 AM and 1:30 AM. V5 stated that he did his rounds at 11 PM, the beginning of shift and saw R1 sleeping in the bed. V5 stated he never provided incontinence care that night to R1 and claimed R1 was not wet when asked.

The CNA's shift schedule is 6:30 AM to 2:30 PM, 2:30 PM to 10:30 PM and 10:30 PM to 6:30 AM per V2 (Acting Director of Nursing) on 10/5/18 at 12:30 PM. The nurses' schedule is 6 AM to 2 PM, 2 PM to 10 PM and 10 PM to 6 AM.

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Review of V10's written statement documents that she was at the nurses' station when at 12:40 PM, she heard someone yelling "help, help". V10 went to R1's room where she saw R1 sitting on the floor mat next to the low bed. There was large amounts of blood on the floor behind resident near the air conditioning unit and blood on the floor mat near her right thigh. There was bleeding and laceration on the left upper side of R1's head. V10's statement documents that V5 did his rounds at 11:40 PM and R1 was sleeping.

On 10/4/18 at 12 PM, V9 (CNA) stated he was assigned to R1 on 7/21/18 for the evening shift (2:30 PM to 10:30 PM). V9 stated that he last toileted R1 before dinner between 4 PM to 5 PM. V9 stated he put R1 to bed at 8:30 PM and left the facility at 9:30 PM. V9 stated he does not know who took over his caseload. V9 was asked if he was ever questioned by V6 about R1's fall and he responded "yes".

Review of the CNA Assignment Worksheet for 7/21/18 shows that there were initially 5 CNAs (V9, V24, V25, V26, V27) scheduled for the evening shift on 2 North. V24 left at 6 PM, V9 and V27 left at 9:30 PM leaving V26 and V25 on the unit.

On 10/5/18 at 10:19 AM via phone, V26 stated she can not remember what the case load was on 7/21/18 evening shift. V26 stated that when that usually happens, the remaining CNA will divide the work load. V26 stated she was never interviewed by V6 (former director of nursing) about R1's fall on 7/22/18.

On 10/5/18 at 10:27 AM via phone, V6 (Former Director of Nursing) stated that it was determined that R1 was getting out of bed to be toileted when

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she had her fall on 7/22/18.

On 10/5/18 at 11:12 AM via phone, V25 stated she can not recall who took care of R1 when the assigned CNA went home. V25 stated that it is the nurse on the unit who does the assigning. V25 stated that usually the CNAs will split the unit not covered. V25 was asked about CNAs giving each other reports from shift to shift and V25 stated that the CNAs usually do not give reports to the following shift.

On 10/5/18 at 11:48 AM via phone, V7 (Licensed Practical Nurse/LPN) stated that when a CNA leaves at 6 PM that CNA does not have assigned residents but will give baths/showers or assist as needed. V7 stated that the CNAs leave at random times and are unable to give each other reports from the previous shifts. V7 stated that she and V28 (nurse) will divide the work load and document it on the CNA assignment worksheet. Informed V7 that the worksheet did not indicate who was assigned to V9 and V27's assignments.

After R1 received her 10 staples and 2 units of blood due to low hemoglobin in the hospital, R1 became unresponsive and family decided to put R1 on hospice which was for one hour before she expired. R1 died within 48 hours from the fall per the facility's final investigation (7/26/18) by V6 (former D.O.N.) and R1's family members (V23 and V21 on 10/2/18 at 8:31 AM, V22 on 10/3/18 at 8:23 AM and V20 on 10/3/18 at 11:28 AM).

The facility's policies labeled Falling Leaf Program and Fall Prevention and Management documents a resident with a Fall Risk Assessment score of 10 or above; and had 2 or more fall incidents inside or outside the the facility within a 30 day period. Interventions will be based

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on the risk assessment and individualized to meet the resident's safety needs. Possible interventions include but limited to: offering toileting or check for any incontinence episodes. Low bed, floor mats and elevated perimeter mattress.

The facility's policy labeled Bowel and Bladder Management documents this policy is to ensure that residents with bowel and bladder incontinence will be identified through proper assessment, and then provided with appropriate treatment and services, helping restore or maintain as much bowel and bladder functioning as possible. A 72 hour elimination pattern assessment flowsheet will be initiated by the restorative nurse while the CNAs are responsible for checking and toileting the resident every hour, documenting on the flow sheet whether the resident was wet or dry and if the resident eliminated when toileted. The 72 hour elimination pattern assessment sheet will help establish resident's voiding pattern. Once an elimination pattern is established, the restorative nurse should develop a planned schedule for toileting the resident. The times are set 10 to 15 minutes before the established pattern so the staff can toilet the resident before she is incontinent. CNAs are responsible for following the schedule and reporting to the charge nurse when the results of following the schedule are not as planned, so that adjustments to the schedule can be made.

(B)