PRINTED: 07/23/2019 FORM APPROVED

Illinois Department of Public Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
E 3		IL6003404		B WING		C 06/11/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	1 00////2010
FRIENDS	SHIP VILLAGE-SCHA	JMBURG		T SCHAUMBU BURG, IL 60°		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETE
S 000	Initial Comments		88	S 000		
	Complaint 1914017	/IL 112736				
S9999	Final Observations			S9999		
	Statement of Licens	sure Violations:				
	300.610a) 300.1210b) 300.1210d)6) 300.3240a)					
	Section 300.610 Resident Care Policies					
	procedures, govern the facility which sha Resident Care Policieast the administrathe medical advisor representatives of nothe facility. These pwith the Act and all of These written policie operating the facility least annually by thi	I have written policies ing all services provide all be formulated by a cy Committee consist tor, the advisory physically committee and pursing and other services shall be in corrules promulgated the es shall be followed in and shall be reviewed a committee, as evided attentions.	ded by a ing of at sician or vices in mpliance ereunder. In ed at enced by			
	Section 300.1210 G Nursing and Person	eneral Requirements al Care	s for			
	care and services to practicable physical well-being of the res each resident's com plan. Adequate and	shall provide the neces attain or maintain the mental, and psychologident, in accordance prehensive resident of properly supervised are shall be provided	e highest logical with care nursing		Attachment of Licensu	

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

Electronically Signed

TITLE

(X6) DATE

07/01/19

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	pepartment of Public				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		IL6003404	B WING		C 06/11/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY 5	STATE, ZIP CODE	00,11,2010
FRIEND	SHIP VILLAGE-SCHAI	UMBURG 350 WES		URG ROAD	
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
\$9999	Continued From pa	ge 1	S9999		
	care needs of the remeasures shall incl following procedure d) Pursuant to nursing care shall infollowing and shall it seven-day-a-week to 6) All necessar	subsection (a), general nclude, at a minimum, the practiced on a 24-hour.			
	as free of accident I nursing personnel s that each resident re and assistance to pr	hazards as possible. All hall evaluate residents to see eceives adequate supervision revent accidents.			
	Section 300.3240 A	buse and Neglect			
	a) An owner, license agent of a facility sh resident. (Section 2-	ee, administrator, employee or all not abuse or neglect a -107 of the Act)			
	These Regulations v by:	were not met as evidenced			:
	failed to safely trans gait belt. This failure	and record review the facility fer a resident by not using a e resulted in the resident g a right knee fracture.			
	This applies to 1 res safety.	ident (R1) reviewed for			
	The findings include:				;
	The facility's Inciden	t report dated August 6, 2018			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6003404	B. WING		C 06/11/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRIEND	SHIP VILLAGE-SCHA		T SCHAUMB BURG, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	LD BE COMPLETE	
S9999	Continued From pa	ge 2	S9999			
	from the wheel char floor landing on his	, 2018 while being transferred ir back to bed, R1 fell to the right kneeR1 did receive a patella fracture as a result of				
	floor landing on his right kneeR1 did receive a non-displaced right patella fracture as a result of					

18KX11

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6003404 06/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 350 WEST SCHAUMBURG ROAD FRIENDSHIP VILLAGE-SCHAUMBURG SCHAUMBURG, IL 60194 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 was counseled in regards to the fall for not using a gait belt during the transfer. The facility's Occurrence Report dated August 1, 2018 shows V6 was the CNA on duty and V5 witnessed the fall and resident stated "feel tired." weak today." R1's Progress Note dated August 1, 2018 shows "R1 fell....orders received to send to hospital Emergency Room for eval and treatment." R1's Hospital Orthopedic Physician Consultation Report dated August 2, 2019 shows "Reason for Consultation- right knee pain and patella fracture after fall.....patient being transferred to wheelchair at the rehab facility when he sustained a fall injuring his right knee....Assessment: status post fall with right nondisplaced patella fracture." R1's Minimum Data Set dated July 31, 2018 shows R1 required extensive assistance of one person for transfers and is not steady, only able to stabilize with staff assistance during surface to surface transfers. R1's Morse Fall Scale dated July 24, 2018 shows R1 is at high risk for falls. The facility's Safe Resident Handling Policy dated January 2018 shows "Gait belt usage is mandatory for all resident assists." (B)

18KX11