STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007009	A. BUILDING: _____ B. WING _____	C 04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE OUR LADY OF VICTORY	20 BRIARCLIFF LANE BOURBONNAIS, IL 60914

(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 1872489/IL101928	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1210 b) 300.1210 d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, 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. These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to identify and implement measures timely to prevent falls. This applies to 1 of 3 residents (R1) in a sample of 4. This failure resulted in R1 incurring a laceration to the forehead which required closure with 4 staples. Findings include: R1's Face Sheet dated February 6, 2016 documents R1 with Dementia. R1's Minimum Data Set dated March 26, 2018 documents R1 with moderately impaired abilities to make daily decision and requiring cues and supervision. R1's Hospice Meeting Note dated December 14, 2017 documents R1 with poor trunkal support. On April 19, 2018 at 8:25am, R1 sat in a high backed reclining adaptive wheelchair being fed	S9999		

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S9999	Continued From page 2	S9999		

breakfast by V14 (R1's Family). R1 had a bandage to the left side of the forehead with yellow discoloration to the mid forehead extending into the left side into R1's hairline. V14 stated R1 has fallen twice in the past 3 week time period and the facility reported they think R1 was leaning forward in wheelchair trying to adjust socks during the last fall.

The facility Resident Incident Report dated March 22, 2018 at 5:45am documents R1 was found on the floor next to the wheelchair with a laceration and swelling to the forehead area. This report documents R1 was sent to the emergency room for evaluation and returned with steri-strips to the forehead as well as bruising to the forehead, eyes and face. The intervention initiated after this fall was to change the time R1 gets up in the morning.

The CNA (Certified Nursing Assistant) Post Fall Tool dated March 22, 2018, completed by V9 (Nursing Assistant), documents R1 as sleeping in her wheelchair. On April 19, 2018 at 7:29pm, V9 stated V9 did not witness R1 fall on March 22, 2018. V9 stated 20 minutes earlier R1 had been up in wheelchair and awake when V9 had last seen R1 and V9 further stated, "I didn't realize I wrote that (R1) sleeping." V9 stated R1 leans forward in the wheelchair a lot messing with shoes and socks. V9 stated R1 is not always steady when R1 leans forward.
On April 19, 2018 at 1:23pm, V7 (Nursing Assistant) stated R1 fell on March 22, 2018 around 5:30am and V7 found R1 on the floor by the nurses station. V7 stated R1 had just been placed there by V9 shortly before R1 was found on the floor. V7 stated, "I am guessing R1 was leaned over messing with shoes and socks. R1 had shoes off..."

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The facility Resident Incident Report dated April 13, 2018 at 9:00am documents R1 was found lying on the floor with a gaping laceration above the left eyebrow and a small skin tear to the left knee. R1 was sent to the emergency room for treatment and returned with four staples to the laceration.

On April 19, 2018 at 12:57pm, V5 (Nurse) stated on April 13, 2018 R1 was observed on the floor with one sock on and one sock off. V5 further stated, "R1 messes with R1's socks a lot. I suspect (R1) fell forward messing with socks (because) R1's wheelchair was locked."

The Post Fall Investigation Tool dated April 13, 2018 documents R4 as a witness and R1 sitting in a wheelchair immediately prior to the fall. This form documents an answer to the question, "Why do you think you fell?" as poor abdominal strength and end state dementia.

R4's Brief Interview of Mental Status dated February 17, 2018 documents R4 as cognitively intact. On April 19, 2018 R4 stated when R1 fell the prior week R4 was sitting next to R1 in a wheelchair. R4 stated R1 suddenly leaned forward and to the left in the wheelchair and fell out.

The facilities Final Report of Incident dated April 16, 2018 documents on April 13, 2018 R1 leaned forward in R1's chair and fell to the floor. The investigation revealed R1 has a history of reaching down to touch R1's feet at times and has poor abdominal strength.

The CNA (Certified Nursing Assistant) Post Fall Tool dated April 13, 2018, completed by V15

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S9999	Continued From page 4	S9999		

(Nursing Assistant), documents R1 needs to be assessed for a new chair as a potential intervention which could prevent R1 from falling again.

On April 20, 2018 at 11:51am, V15 stated he was caring for R1 on April 13, 2018 but did not witness R1 fall. V15 stated in the last 30-60 days R1 has been leaning forward in the wheelchair and V15 could not indicate if this information had been reported. V15 stated R1 has a history of leaning forward, is "fidgety" and has weak abdominal muscles which causes a problem when R1 tries to sit up. V15 stated R1 is a "priority high risk" resident due to a previous fall and exhibits high risk behaviors of leaning forward in the wheelchair, reaching for things on the floor and falling asleep in the wheelchair. V15 stated since R1 was provided the new high backed reclining adaptive wheelchair R1 is a lot safer, not leaning forward and can lift R1's foot up onto R1's lap to reach shoes and socks.

On April 19, 2018 at 11:20am V7 (Nursing Assistant) stated R1 is constantly reaching down to mess with socks and shoes. V7 stated R1 shakes sometimes when leaning forward and isn't always steady. V7 stated R1's new high backed reclining adaptive wheelchair reclines back enough to position R1 better. V7 stated if R1 falls asleep she is placed in bed for safety.

On April 20, 2018 at 9:30am, V11 (Nursing Assistant) stated R1 would lean forward and remove socks. V11 stated some days R1 was steady when leaning forward in the wheelchair and other times R1 was not. V11 stated R1 was frequently placed by the nurses station for increased supervision so R1 didn't fall. V11 stated R1 was at risk for falls due to being

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S9999	Continued From page 5 unsteady and leaning forward in the wheelchair. On April 20, 2018 at 11:06am, V17 confirmed V17 was functioning as the Fall Coordinator at the time of R1's recent falls. V17 stated the facility assesses all residents for fall risk, implementing individualized interventions as appropriate to address residents risks. V15 stated R1 has had a small steady decline due to dementia. V15 stated due to dementia when R1 loses R1's balance R1 lacks the cognition to correct her posture. On April 20, 2018 at 1:12pm, V17 stated R1's get up time was changed after the information gathered after the fall on March 22, 2018 indicated R1 was sleeping in the wheelchair at the time of the fall. V15 stated she was not aware of R1's leaning forward in the wheelchair removing socks/shoes as a problem. On April 20, 2018 at 12:19pm, V13 (Nurse Practitioner) confirmed the facility should have addressed R1 leaning forward in the wheelchair sooner to keep R1 safe from further falls due to leaning forward in the wheelchair. The facility policy Falls Prevention Program dated November 22, 2016 documents it is the policy of the facility residents will be assessed for Fall Risk and that appropriate interventions will be put into place to prevent the risk of fall. (B)	S9999		