

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010664	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/23/2018
NAME OF PROVIDER OR SUPPLIER ST JAMES WELLNESS REHAB VILLAS			STREET ADDRESS, CITY, STATE, ZIP CODE 1251 EAST RICHTON ROAD CRETE, IL 60417		
(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: 1872399/IL101828	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 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999			
			Attachment A Statement of Licensure Violations		

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

TITLE

(X6) DATE

05/08/18

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S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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: These regulations were not met as evidence by: 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, seven-day-a-week basis:	S9999			

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S9999	Continued From page 2 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. Based on interview and record review the facility failed to provide assistance to a resident identified as high risk for falls, needing two-person physical assistance and use of gait belt during the transfer to promote resident safety. The applies to 1 of 3 residents (R5) reviewed for falls in the sample of 10. This failure resulted in R5's fall during a one-person assisted transfer, which was also without the use of a gait belt that resulted in the fracture of R5's femur (thigh bone). The findings include: R5 was admitted to the facility January 22, 2016. R5's diagnoses included urinary tract infection, pneumonia, generalized muscle weakness, anemia, abnormal posture, major depressive disorder, hypertension, and dementia. R5's MDS (February 24, 2018) showed she was cognitively intact with a BIMS score of 12 of 15. R5's MDS also showed (R5) required extensive assistance of two staff when transferred from bed to chair or wheelchair. R5's fall risk assessment (dated January 19,	S9999			

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S9999	Continued From page 3 2018) showed R5 was at high risk for falling. The facility initial and final reportable documents showed that R5 had a fall incident on March 13, 2018 at 7:47AM: The final report stated in part, Staff rendering care were interviewed and the staff stated that they were transferring R1 from the bed to the wheelchair when (R5's) legs gave out. Staff assisted (R5) and lowered (R5) to the floor. Staff stated R1 did not fall. Staff stated that they lowered (R5) to the floor... X-ray revealed right femur fracture." The report documented the physician was notified and gave orders to send R5 to the hospital for further evaluation, and R5 was admitted to the hospital. R5's medical records were reviewed and showed that on March 15, 2018, R5 fell while being transferred from the bed to the wheelchair, while being assisted by one staff. The records showed the fall resulted in a fracture of the lower end of R5's right thigh bone, which required hospitalization for treatment. April 16, 2018 at 4:15PM, R5 stated (R5) fell but couldn't remember how. R5 had a cast on R5's right leg (from her thigh to foot.) R5 stated "they put the cast on when I went to the hospital after I fell", she would "be glad" when it is removed, stating "it's hard to move around with it." April 18, 2018 at 9:45AM, V2 (Director of Nursing) confirmed R5's fall occurred when V13 (CNA) transferred R5 alone and without the use of a gait belt. V2 stated there should have been two staff making the transfer. V2 also stated V13 should have used a gait belt, and stated V13 did not use	S9999			

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S9999	Continued From page 4 a gait belt during the transfer. V2 stated it was facility policy for a gait belt to be used during transfers. April 19, 2019 at 5:15PM, regarding prevention of R'5 fall with fracture, V14 (R5's Physician) stated "it would have been better if there were two staff during the transfer, and confirmed that a gait belt should have been used during the transfer. The facility provided their policy which required the use of a gait belt during transfers. The "Safe Patient Lifting Policy" (undated) stated: "Gait belt usage is mandatory for all resident handling.... The gait belt will be considered a part of the certified nursing assistant's uniform." (B)	S9999			