STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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 # 1873419/IL102916	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATION 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)4)5)A) 300.3240a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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
S9999	Continued From page 1	S9999		

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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
S9999	Continued From page 2	S9999		

hygiene, in addition to treatment ordered by the physician.

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 observation, interview and record review, the facility failed to provide treatment and services to promote healing and prevent the worsening of R1's pressure injury on R1's coccyx. The facility also failed to consistently implement the plan of care to maintain head of bed at lowest elevation.

This failure resulted in the worsening of R1's identified erythema (superficial reddening of the skin) on R1's coccyx to the development of necrotic area (Unstageable) wound on R1's coccyx.

This applies to one of three (R1) residents reviewed for the development of pressure injury in the sample of 8 residents.

The findings include:

R1 is an 89 year old resident dependent on staff for all activities of daily living and R1's current wound rounds plan dated April 27, 2018 showed to "off load pressure." R1's skin care plan for skin care documented an intervention to maintain head of bed at lowest elevation.

On May 29, 2018 at 10:45 AM, R1 was noted sitting in an upright position in bed (at an 80 degree angle). R1 was noted to be sleeping. R6 (R1's roommate) stated, "(R1) does not talk and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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
S9999	Continued From page 3	S9999		

has a sore on R1's buttocks from sitting for too long. No, they really do not take (R1) to the bathroom. They (staff) come and change R1's diaper."

At 12:40 PM, R1 remained in the same position in bed (at 80 degree angle).

At 3:01 PM, R1 was noted in bed sleeping, flat on R1's back. A wrinkled draw sheet and a towel underneath R1's lower back (buttocks and mid-thigh) were noted. V3 (Nurse) was asked to check R1 for incontinence. R1's disposable incontinence brief was noted to be saturated with urine and soiled with feces. R1's buttocks and wound dressing were smeared with feces.

V9 (wound nurse) and V10 (wound nurse) described R1 as non-verbal, pleasant and cooperative with care. V9 and V10 also described R1 as dependent on staff with activities of living and needing staff to perform repositioning.

On May 30, 2018 at 1:49 PM, V1 (Administrator) explained that on May 24, 2018, R1's Power of Attorney requested a meeting with (V1) and the ex-Director of Nursing to discuss the development and worsening of R1's pressure injuries. V1 said, "R1's family presented pictures of R1's wounds (coccyx, and on the right and left toes.) They said R1's wound was caused by us (acquired in the facility) and R1's family wants to know what we are going to do about it. I told them that the wound care team will investigate it. R1 is a heavy wetter and sits in R1's chair for a long time and at night R1's excessively wet. According to the wound team when they are doing their rounds they always found R1 excessively wet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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
S9999	Continued From page 4	S9999		

The problem is the night shift; they (staff) are not turning R1 enough or not changing R1 enough. I should have addressed this right away."

On May 29, 2018 and on May 30, 2018, V9 and V10 (Wound Nurses) presented the wound rounds documentations (with pictures) and explained, "On April 5, 2018 the nurse noted an erythema (superficial reddening of the skin) on R1's coccyx but documented it as a Stage 2, then documented it as healed. This assessment was incorrect, it was not a Stage 2 yet it's just an erythema. On April 13, 2018 (8 days after) when we were first notified by the floor nurse and this area was a Stage 2 already (measured at 2.0 cm X 2.0 cm X 0.2 cm). On May 2, 2018 assessment the wound was covered with necrotic (black) area (Unstageable pressure injury, measured at 3.0 cm X 2.5 cm X 0.2 cm."

On May 29, 2018 R1's pressure injury on the coccyx was identified by V9 and V10 with 100% necrotic area measuring 3.0 cm length X 3.0 cm width X 1.20 cm depth.

On May 30, 2018 at 11:15 AM, via phone interview, V11 (Wound Doctor) stated, "I was asked to evaluate R1 that has an Unstageable pressure area (on the sacro-coccygeal) due to necrosis. I probably saw R1 2-3 times only. Yes, this is pressure related because the wound was located on a bony area. R1 should not had been positioned in an 80 degree angle, because it would result in increased pressure on the wound. The area (coccyx) should have been off loaded to promote healing. My recommendation is to position R1 from side to side only when in bed. I do not have any recommendation regarding incontinence aside from keeping the area clean and dry. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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
S9999	Continued From page 5	S9999		

(B)