Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:    IL6011910			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	C 05/04/2021			
	PROVIDER OR SUPPLIER	1400 BRC	DRESS, CITY, DOKDALE R			8
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	DBE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga 2172885/IL 13334					
S9999	Final Observations		S9999			
	Statement of Licens 300.610 a) 300.1210 b)5) 300.1210 c) 300.1210 d)6)	sure Violations:	356			
The state of the s	a) The facility shall procedures governing facility. The written be formulated by a life Committee consisting administrator, the amedical advisory conforming and other policies shall comply the written policies the facility and shall	dvisory physician or the mmittee, and representatives revices in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed				
	Nursing and Person b) The facility shall and services to attai practicable physical, well-being of the res each resident's com plan. Adequate and care and personal c	provide the necessary care in or maintain the highest mental, and psychological sident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal		Attachment A Statement of Licensure Violation	8	

STATE FORM

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
IL6011910		B. WING		_	C <b>05/04/2021</b>	
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 00.0	
I AL PARKILIN'A RESILIENLE			OKDALE R LLE, IL 605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
S9999	Continued From page 1		\$9999			
	encourage residents transfer activities as effort to help them re practicable level of to c) Each direct care be knowledgeable as respective resident	e-giving staff shall review and about his or her residents' care plan.				
	care shall include, a and shall be practice seven-day-a-week b 6) All necessary to assure that the re as free of accident h nursing personnel st	pasis:  y precautions shall be taken sidents' environment remains nazards as possible. All hall evaluate residents to see eceives adequate supervision				
	This REQUIREMEN	T is not met as evidenced by:				
	failed to follow their parametering a reside This failure resulted comminuted fracture	riew and interview, the facility policy and procedure while nt using a mechanical lift. in R1 sustaining a of the right clavicle. This dents (R1) reviewed for fall in				
	Findings Include:					
η 	is an 82-year-old fen facility on February 1					
		12:35 PM, R1 said she on the floor. She was being	į			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		DERTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		IL6011910	B. WING		C 05/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, 8	STATE, ZIP CODE		
ST PATRICK'S RESIDENCE 1400 BROOKDALE ROAD NAPERVILLE, IL 60563						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT IN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
S9999	Continued From pa	ge 2	S9999			
	transferred to her w was only one perso a male staff. Then	wheelchair from the bed. There in doing the transfer and it was staff came in and got her up wheelchair. R1 also said she	64	*	39 50 50	
5- 13-	Practical Nurse) sa (CNA/Certified Nursalone while transfer	9:35 AM, V7 (LPN, License id on March 22, 2021, V8 sing Assistant) was working ring R1 with a mechanical lift.		2.5 (h)	==	
id	Department of Publ March 22, 2021 at 8 Nursing Assistant) v bed to her wheelch himself. The "Corre report showed unde wrote, "I responsible co-worker was busy	nt report sent to IDPH (Illinois ic Health) shows that on 5:15 AM, V8 (CNA/Certified was transferring R1 from her air using a mechanical lift by ctive Action Notice" in the er "Employee's Comments" V8 e for last night's incidentMy and resident kep (kept) that she wanted to get-up-get-up alone."		3 %		
**	ADLs (Activities of I to be transferred wi assistance of two st Data Set (MDS) dat	d February 8, 2021 under Daily Living) shows that R1 is th a mechanical lift, with taff members. R1's Minimum ted February 16, 2021 shows lent on at least two staff er.	С	(S)	al	
	5:15 AM, R1 fell fro being transferred. A received results of I sent to the hospital	s shows on March 22, 2021 at m a mechanical lift while at 12:40 PM, the facility R1's x-ray and R1 was then for evaluation and treatment. turned from the hospital with a ured clavicle.		*1		

Illinois Department of Public Health

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_\_ B. WING IL6011910 05/04/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 BROOKDALE ROAD ST PATRICK'S RESIDENCE NAPERVILLE, IL 60563 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S9999 Continued From page 3 S9999 R1's hospital documentation dated March 22, 2021 under the title "Emergency Provider Notes" shows R1 was lifted with a mechanical lift and she fell out of it and landed on her buttocks area. her right shoulder, and right side of her head. R1 stated most of her pain was in her shoulder. R1's Right clavicle x-ray result dated March 22, 2021 under conclusion shows "Comminuted and midly angulated fracture mid to distal 3rd of the right clavicle is noted." The facility's policy and procedure titled "Lifting" Machine, Using a Mechanical" dated July 2017 under the subtitle "General Guidelines" shows "1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift ..." On April 30, 2021 at 1:50 PM, V1 (DON/Director of Nursing) said that all transfers with a mechanical lift should be done with two staff because residents are unpredictable, and it is the facility's policy.

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