STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145637	A. BUILDING _____ B. WING _____	04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH VILLAGE OF CHICAGO	4021 WEST BELMONT CHICAGO, IL 60641

(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) COMPLETION DATE
F 441	Continued From page 19 On 4-26-2012 at 9:41AM E10(Nurse) stated, "Oh I should wash my hands laughed and then said, I will wash my hands now."	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)5) 300.1210c) 300.1210d)3)6) 300.3240a) 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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:	F9999		

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F9999	Continued From page 20 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. 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. These requirements were not met as evidence by: Based on observation, record review and interview, the facility failed to maintain fall prevention measures for 1 of 8 residents (R7) reviewed for falls in a sample of 12. R7 has a history of falls: 6/18/11 sustained a left hip fracture and 3/1/12 sustained a left femur fracture with left prosthetic hip dislocation. Findings include: 1. R7 was admitted to the facility on 12/9/10 with diagnoses including Dementia, Depression, Failure to Thrive, Left Mid-Knee Amputation and history of falls. Care plan dated 4/17/12 describes R7 as having	F9999		

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F9999	Continued From page 21	F9999		

long and short term memory deficit, modified impaired cognitive skills for daily decision making and periods of inattention and disorientation.

Incident Report dated 6/18/11 shows R7 sustained an unwitnessed fall in the dining room at 6:20 p.m. Report states that staff heard a loud noise, alarm went off and R7 was observed on the floor. Upon assessment, R7 complained of pain when left leg was touched and noted with shortening and external rotation of the left leg. R7 was sent out to the hospital and diagnosed with Left Hip Fracture and underwent Hemiarthroplasty of Left Hip.

Fall prevention interventions that were in place at time of fall includes use of non-slick footwear, safety alarm device when up in chair and in bed, engage in ambulatory program, instruct on safety measures to reduce fall risk, instruct on use of call light, bed in lowest position with wheels locked.

On 9/29/11 R7 was eased down to the floor by staff during transfer with staff assist. R7 did not sustain any injuries.

On 3/1/12 staff heard a loud noise coming from R7's room and R7 was found lying on her left side. R7 was in a confused state and unable to say what happened. A full body assessment was done and no injuries found.

Nurses' notes dated 3/3/12 at 3:11pm states R7 was found to have a swollen left knee and the left leg looked shorter than right. Stat X-ray examination of the left hip and knee was ordered. There is no evidence that R7 was assessed for

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F9999	Continued From page 22	F9999		

pain in the affected area. X-ray report dated 3/3/12 shows "displaced" head of left femur prosthesis. There was no result reported for the left knee X-ray. At 11:52 pm, R7 was exhibiting agitation especially when touched or moved. On 3/4/12 at 11:21 am, R7 complained of pain when being turned. On 3/5/12 at 12:57 a.m., R7 was observed with left knee redness and swelling and complained of pain "to all areas". An amended X-ray report was received on 3/5/12 which showed "dislocated" head of left femur, and left knee X-ray showed an "oblique and slightly spiral fracture of the distal shaft of the femur". R7 was then sent to the hospital for evaluation, 5 days following the fall. Hospital progress notes shows a diagnosis of Oblique, Osteopenic, Displaced Left Femoral Shaft Fracture. R7 underwent open reduction of the left femoral shaft fracture.

On 4/24/12 at approximately 10:15am, R7 was in bed, alert but confused, with unintelligible speech. R7's call light was not within easy reach. E3 (Nurse-Care plan coordinator) was present and stated that R7 is able to use the call light, and proceeded to adjust the location. E3 went on to say that R7 is at high risk for falls and uses body sensor alarm and fall mats on both sides of the bed. At approximately 12:30pm, R7 was in her bed, alert and apparently confused. R7 was lying on her left side, propped into position with pillows. R7 appeared to have poor trunk control, requiring total assist with bed mobility. Minimum Data Set (MDS) dated 4/12/12 confirms R7 poor trunk control. The floor mat to the left side of the bed was not in place. Z1, Volunteer, was present in R7's room and was frantically verbalizing concern for R7 lying on her left side with only upper side rail in place and the missing floor mat. Z1 stated

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F9999	Continued From page 23 that R7 should have full side rail to prevent another fall related serious injury. Z1 went on to say that she often enters R7's room and finds fall mats not in place. E5 (Certified Nurses Aid-CNA) entered the room approximately five minutes later and stated that she was in the process of feeding R7. E5 made no attempt to put the missing floor mat in place. At 1:30pm, surveyor entered R7's room accompanied by E4 (Restorative Nurse). R7 was still lying on her left side, left floor mat was not in place, the bed was not in it's lowest position. E4 stated that these measures should be in place at all times and immediately educated E5 on the importance of maintaining fall prevention measures. Review of R7's current care plan dated 4/17/12 shows no inclusion of use of safety alarms, fall mats at both sides of the bed and bed in lowest position. E3 (MDS/Care Plan Coordinator) provided surveyor with an updated care plan dated 4/24/12 which incorporates these additional interventions. E3 stated that she omitted the inclusion of these measures in the care plan. "B"	F9999		