STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145029	A. BUILDING _____ B. WING _____	C 02/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA 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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1170498 - IL51829.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop and implement interventions for the use of an appropriate assistive device as a measure to prevent a resident (R1) from falling. As a result: On 2/7/11 R1 who is unstable to transfer and ambulate, got up from bed, ambulated and fell and sustained right hip fracture. This is for one of three (R1) residents in the sample. Findings include: R1's admission record indicated she was originally admitted to the facility on 12/22/10 after she underwent a left lower lobe thoracotomy for squamous cell carcinoma. After R1 was admitted to the facility she was hospitalized from 1/18/11 to 1/22/11 for evaluation and treatment of chest pain and was re-admitted to the facility on 1/22/11. On 2/7/11 the facility sent R1 to hospital	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F 323	Continued From page 1 for the evaluation and treatment of a fall. At the hospital it was diagnosed that R1 sustained right hip fracture. A review of R1's Nurses Notes and facility incident reports indicated during her stay (12/22/10 - 2/7/11) in the facility she fell on 1/12/11 while reaching for the Oxygen tubing. On 1/13/11 the facility added to the fall prevention interventions 'encourage to use call light when needing something, and add clip alarm while in bed.' R1 also moved close to the Nurses Station for close supervision. It was also documented on 2/7/11 at 9:30 pm that R1 was found on floor. This time per Nurses Notes and incident report, the staff heard R1 yelling for help. When the staff responded R1 was found on the floor couple feet away from her foot of bed on her way to bath room. The bed alarm was unclipped, bed was in low position. R1 sustained a bump on back of her head and complained of pain all over. At the Hospital it was diagnosed that R1 sustained right hip fracture. The facility identified R1 to be at risk for falling per Minimum Data Set (MDS) assessment of 1/7/11 and 2/7/11). The MDS also identified R1 to be unstable, but able to stabilize without human assistance in the areas (a) moving seated to standing, walking, moving on and off toilet, (b) transfer to and from bed to chair. However the the MDS also indicated turning around and face opposite direction activity did not occur. R1 12/22/10 care plan for fall prevention interventions are generalized not specific to her needs. Examples of non-specific interventions are: (a) 'frequent visual checks,' this intervention	F 323		

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F 323	Continued From page 2 is generalized. (b) 'instruct and remind resident to avoid rising rapidly,' R1 is confused and unable to recall one out of three words. It is unclear how the facility will ensure R1 will follow the instructions. (c) 'side rails based on assessment,' it is not clear with the intervention if R1 is to have side rails, if so what kind and why? (d) on 1/13/11 after her falling on 1/12/11 the facility added an intervention 'encourage to use call light when needing something and add clip alarm while in bed,' again when R1 is confused and disoriented how the facility will ensure that she will comply with staff encouragement. The facility incident investigation of 2/7/11 staff interviews indicated R1 is confused, knows how to remove the alarm when ever she tries to get up by herself. The investigation also indicated she R1 has short term memory impairment, does not remember to use call light, require staff assist for transport, transfers sit to stand with standby assistance. E4, the Nurse who was on duty on 2/7/11 evening shift stated that per R1's Certified Nurse Aide (CNA) she met all of R1's needs before she put her to bed. E4 stated R1 unclips the alarm when she is in chair and when in bed when ever she wants to get up out of confusion. E4 also stated R1 gets irritated with the alarm sound when ever she moves and refuses to have it on. R1's such behavior from confusion has been more frequent after her recent hospitalization for decline in her medical condition. If there was a movement sensor alarm on bed probably the staff would have been able to get to R1 before she got out of bed. E6, the Certified Nurse Aide (CNA) who was	F 323		

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F 323	Continued From page 3 assigned for R1 on 2/7/11 evening shift was interviewed on 2/17/11. E6 stated that when R1 was originally admitted (12/22/10) to the facility she was taking care of R1 because her room was in her section of the hall. E6 has not taken care of R1 after she was moved to another room nearer to Nurses Station. On 2/7/11) was the first day she was assigned to care for R1 since (1/22/11) her readmission after hospitalization. E6 also indicated R1 got increasingly confused, after her hospitalization. E6 stated she put R1 to bed just 20 minutes before she fell. R1 had her bed alarm clipped to her blouse, bed side rails were up, bed was in low position, does not recall if there was a floor mat on the floor. No one heard R1's bed alarm go off, she heard from the hallway R1 calling for help. When E6 responded she found R1 on the floor couple steps away at the foot of bed on way to bath room. R1's bed alarm was unclipped from her blouse and it was on her bed. E6 concluded, if there was a movement sensor alarm on her bed, may be she would have caught her before she got out of bed. On 2/17/11 E5, the Director of Nurses stated the facility implements progressive restrictive measures. E5 indicated during the investigation of the incident they became aware that the direct care staff knew that R1 was removing the clip alarm. The next intervention for R1's fall prevention would have been chair belt with removal sensor, and movement sensor bed alarm when returned to the facility, but she did not come back. E5 concluded placing movement sensor bed alarm was not quick enough.	F 323		