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 11/21/2013

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

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F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Investigation of Complaint 1374674 / IL 66548 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 interview and record review the facility failed to provide necessary supervision to prevent a fall and failed to follow their policy and procedure for following the resident care plan for increased supervision during toileting. These failures resulted in a fall incident with abrasions to the knee and forehead for 1 of 3 sampled residents R1. The findings include: The admitting history and physical report from the hospital dictated by Z2 (physician) on 10/9/13, and the facility nurses's admission notes on 10/28/13 show, R1 was admitted to the facility after a hospitalization from a fall that occurred at home. According to the hospital history and physical report, R1 was diagnosed to have had a right sided Cerebrovascular accident. R1's symptoms included left sided weakness, a hemorrhage stroke process(intraparenchymal bleed), a history of Chronic Obstructive	F 323		

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

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F 323	Continued From page 1	F 323		

Pulmonary Disease, hypertension, chronic arthritis and compression fracture of the left femur fracture that occurred in the fall at home. Prior to the admission R1 was able to ambulate with a cane or walker.

R1's Medicare Charting dated 10/31/13 show R1 requires ADL (activity of daily living) assistance of 1-2 people. A care plan stamped 10/28/13 for R1 was reviewed on 11/08. E2 (director of nurse)stated on 11/08/13 at 2 p.m. the care plans are kept inside each residents closet door. The care plan showed R1 should not be left alone. The nurses notes on 11/01/13 show R1 was left alone on the toilet by E3 CNA (certified nursing assistant) on 11/1/13.

"The Resident Incident Review" report dated 11/1/13 show E15 (nurse) at 8:15 a.m. was called to the room by E3 stating R1 fell in the bathroom on the toilet and was found to have an abrasion to the left knee and forehead. E 15 wrote R1 was on the floor on her right knee and hit her forehead on side of the sink. She sustained an abrasion to both forehead and right knee noted.

E1 (director of nurses), on 11/08/13 at 2 p.m. said the care plan for R1 was inside the closet for R1. E2 stated E3 did not follow the care plan by leaving R1 left her alone on the toilet E1 said every resident's care plan is kept inside their closet doors. E1 stated the facility's procedure is to inform the staff about the care each resident receives by putting the care plans inside each residents door. The CNA's are to use this information as guides to deliver the the individualized care and services needed for each resident. E2 stated E3 was terminated for not

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F 323	Continued From page 2 following the facilities policy's and procedures and leaving R1 alone in the bathroom.	F 323		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure certified nursing assistants are competent in skills and techniques to transfer 1 of 3 sampled residents R1 who required the use of a sliding board for transfers. The findings include: The admitting history and physical from the hospital dictated by Z2 (physician) on 10/9/13, and the facility 's nurses admission notes on 10/28/13 show R1's was admitted to the facility after a hospitalization from a fall that occurred at home. According to the hospital history and physical report, R1 had a right sided Cerebrovascular accident. R1 had left sided weakness, a hemorrhage stroke process(intraparenchymal bleed) and a history of Chronic Obstructive Pulmonary Disease, hypertension, chronic arthritis and compression fracture of the left femur fracture that occurred in the fall. Prior to the admission R1 was able to ambulate with a cane or walker. Rehabilitation goals for R1 completed by Z3 (physician) on	F 498		

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F 498	Continued From page 3	F 498		

10/21/13 show a care plan developed to improve transfers to a level of supervision possibly using sliding board, prevent fall and provide fall education, improve endurance to tolerate therapy and gait training with a hemi cane to a level of supervision.

On 11/8/13 the nurses notes for 10/30/13 were reviewed with E2 (director of nurse). The concerns from Z1 were reviewed about the staff's education in relation to general care areas, and staff unable to transfer R1 into bed by use of a transfer sliding board. E2 stated the staff are trained on the use of the transfer board and it is documented on the CNA Mandatory Skills Check during their initial orientation period. The Mandatory Skills Check sheets were reviewed with E1 and E5 (nurse unit manager). The skill transfer sliding board was listed on the form. E2 and E5 were unable to show how the facility can show the staff are competent in the skill of transfer board technique. E2 stated, E14 (restorative nurse) checks this skill off during orientation. E2 could not present how the facility is verifying their staff is trained in this skill.

On 10/28/13 E12 and E13, CNA's (certified nursing assistants) attempted to transfer R1 with the use of a sliding board. Present in the room were Z5 and Z1 (family). Z5 stated at 4 p.m. on 11/8/13 and Z1 stated on 11/8/13 that E12 and E13 were unable to complete the skilled technique of transferring R1 into bed with the sliding board . E12 and E13 were trying to get R1 onto the transfer board and could not figure out how to do it, Z1 and Z5 stated R1 was picked up and placed into bed by Z1 due to all the confusion and the staffs inability to perform the task.

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F 498	Continued From page 4	F 498		

E12 stated on 11/20/13, " not ever using the transfer board prior to this event. E12 stated receiving orientation after 10/28/13 on the use of the transfer board and was more comfortable with it's use after returning a demonstration to E14 (restorative nurse) on the proper technique. E12 stated after the attempt to transfer she recalled speaking to E14 about how to perform the transfer. E14 said this made her more comfortable with the technique. E12 could not recall receiving orientation on this skill prior to 10/28/13.

On 11/20/13 at 2:15, E13 CNA stated receiving orientation on how to transfer residents with the use of the sliding board. E13 said she had only been a new CNA for four months and had never used the transfer sliding board before 10/28/13 to transfer a resident. E13 stated a week after the event on 10/28/13 the facility held training inservices on how to transfer residents with sliding boards. E13 stated Z1 acted impatient with them on 10/28/13 and just decided to pick R1 up and put into the bed. E13 recalled the event and later stated probably appeared nervous during the transfer because had never used a transfer board to transfer a resident before.

Review of R1's care plan on 11/8/13 show a plan with a goal for R1, " not to experience falls and interventions included to assess for appropriate lift equipment as needed:10/28/13 sliding board transfer, 10/30 d/c sliding board and change to 2 person pivot transfer". This was written after the staff's inability to use the transfer sliding board technique.