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	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Village of Chicago	4021 West Belmont Chicago, IL 60641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45001 Based on interview and record review the facility failed to put interventions in place for a newly admitted resident (R199) in a sample of 12 residents. This failure resulted in R199's skin intact with redness progressed to stage three wounds of the buttock and heel. Findings include: According to R199's face sheet printed 6/12/2024, R199 is [AGE] years of age and was admitted to the facility on [DATE] and discharged [DATE]. R199 diagnoses include but are not limited to aftercare following explanation of shoulder joint prosthesis; unspecified rotator cuff tear or rupture of left shoulder; arthropathies, left shoulder; polyosteoarthritis; pressure-induced deep tissue damage of left heel and right buttock with onset date 5/10/24; pressure ulcer of left heel and right buttock, stage 3 with onset date 5/22/24. R199's Admission Evaluation, dated 5/10/2024, indicates skin intact. According to R199's POS (Physician Order Summary) printed 6/12/24, the following orders were placed for R199, air loss mattress, order date 5/22/24; apply alginate calcium to right buttock after cleansing NSS then cover with gauze island dressing every night shift for open wound, order date 5/22/24; apply alginate calcium with leptospermum to left heel after cleansing NSS then cover with gauze island dressing every night shift for open wound, order date 5/22/2024; off load the wound, reposition per facility protocol, float heels, limit sitting for 60 minutes, order date 5/22/24. R199's TAR (Treatment Administration Record) dated May 2024, indicates wound care treatments with start date of 5/22/24 to right buttock and left heel. Treatments completed 5/22, 5/23, 5/24. R199's progress note 5/10/2024 8:10 PM (20:10) documents in part: resident skin intact with redness to buttocks, redness to left heel, resident has bruising to left arm, chest, back and abdomen area, bruising to right arm. R199's progress note 5/14/2024 9:00 PM (21:00) documents in part: Also has sore present on foot. R199's progress note 5/16/2024 3:39 PM (15:39) documents in part: wound care to follow for heel pressure ulcer. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

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St Joseph Village of Chicago	4021 West Belmont Chicago, IL 60641

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R199's progress note 5/19/2024 6:27 PM (18:27) documents in part: Also family meeting scheduled today feels well, receiving supplements for pressure ulcer, yet to be seen by wound care MD. Specialty Physician Initial Wound Evaluation and Management Summary, 5/22/2024, documents in part: Stage 3 pressure wound of the left heel full thickness; etiology, pressure; duration greater than 14 days; wound size, 1.7 x 3.1 x not measurable cm, dept is unmeasurable due to presence of nonviable tissue and necrosis. Stage 3 pressure wound of the right buttock full thickness; etiology, pressure; duration greater than 14 days; wound size, 1.5 x 1.7 x 0.1 cm. On 6/12/24 at 9:34 AM, V17 (Wound Care Nurse) stated V17 has been at the facility as wound care nurse for three years. I'm here one day a week. The night shift nurse does treatments when I'm not here. The Facility does skin assessments on admission and weekly. Treatments are documented on the TAR (Treatment Administration Record). There is only an admission note for R199. I saw R199 with the wound doctor on 5/22/24. When R199 was admitted the nurse charted redness on the left heel and buttock. The doctor charted redness on left buttock and left heel. On 5/22/24 the left heel and left buttock were stage 3, they were open. Redness is not an open wound it is intact. 5/22/24 ordered a low air loss mattress. There were no treatments for the redness. Usually for redness in the buttock area there is an order for barrier cream to prevent from getting worse. Heel protectors or off-loading for redness on the heels to prevent from getting worse. I don't know if that was done. I was not here the day R199 was admitted . The wounds were acquired in the facility. 5/22/24 order for alginate calcium and Medi honey to left heel, alginate calcium to the buttock. The doctor or I did not see R199 after 5/22/24. On 6/14/24 at 12:18 PM, V28 (Wound Care Physician) stated R199 had two wounds, one on the heel and one on the buttock. My date of service is 5/22/24. R199 was admitted 12 days before I saw R199. On 5/22 the heel, post debridement, was stage 3, the buttock was stage 3. I did not debride the buttock. I can't base my presumption on someone else's note I can only base it on my own. I would have seen R199 when they told me to see R199. I would not have delayed seeing R199. The floor nurses notify myself and or the wound care nurse of any new wounds that they want me to see. I round once a week, Wednesday mornings starting at 6AM. Facility system procedure, Skin and Wound Care Program, 2/12/2023, documents in part: To provide clinical systems and resources to identify residents at risk for skin breakdown; implement strategies to prevent and/or manage pressure ulcers and reduce pain and minimize infection; reduce and mitigate the overall incidence of pressure ulcers; reduce risk factors that contribute to the development of pressure ulcers; monitor the incidence and severity of pressure ulcers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on interviews and review of records the facility failed to provide effective supervision, interventions and monitoring to prevent falls per policy for a resident that needs maximal assistance with ADLs/Activities of Daily Living (bed mobility, transfers, and ambulation). Facility also failed to ascertain or to rule out injury had occurred due to the fall. These failures include 1 out of 1 resident (R49) in a total sample of 12 residents reviewed for accidents and hazard. This failure resulted in R49 having 2 falls for a period of 6 days in the facility. R49 sustained left leg/hip severe pain and left leg/hip (femoral) fracture that was determined the day after discharge. Findings include: R49 was [AGE] years old, admitted on [DATE] for respite of 6 days until 1/29/2024. R49 medical diagnosis includes vascular dementia, convulsion, cerebral atherosclerosis. R49's progress notes for history and physical by V4 (Medical Doctor) dated 1/25/2024 documents that R49 was seen confused alert to self only. R49 needs fall and safety precautions. Per R49's progress notes by V10 (Licensed Practical Nurse) dated 1/25/2024 (verified by V2 (Acting Director of Nursing actual date was 1/24/2024) around 6:30 PM, an aide informed V10 that R49 was observed laying on the floor on her left side. Per R49's progress notes by V11 (Licensed Practical Nurse) dated 1/26/2024 documented that another fall incident happened. Per notes, R49 was again observed on the floor. Multiple notes of R49 with pain to the left leg after the first fall are as follows: V10 documented on 1/25/2024 at 6:30 PM for post fall monitoring that R49 was complaining of left leg pain when hospice staff did a range of motion on R49. V10 documented on 1/25/2024 at 11:00 PM during evaluation or assessment there was pain at left lower extremity, posterior thigh. V12 (Licensed Practical Nurse) documented on 1/28/2024 for post fall charting, that R49 complains of severe pain throughout the shift. After Tylenol was administered around 6:00 PM, R49 continues to complaint of severe pain on the left leg. Morphine was administered around 8:20 PM continue to monitor pain. On 06/12/2024 at 1:47 PM, V10 (Licensed Practical Nurse) stated, I was the nurse when R49 fell . I called the doctor and hospice. Hospice nurse came in the facility and did ROM (range of motion). But hospice did not want to pay for X-Ray. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/12/2024 at 12:12 PM, V2 (Acting Director of Nursing/Infection Control Preventionist/Restorative) said R49 fell twice during her 5 days stay in the facility. The first fall was on 1/24/2024 at 6:30 PM and another fall on 1/25/2024 . Hospice came early morning 1/26 after the fall. V2 said that she noted that there was documentation of R49 having severe pain on 1/28/2024. V2 said that there was no X-Ray done on record. And that the facility was not aware of any injury R49 sustained due to the fall. On 06/12/2024 at 02:00 PM, V20 (Minimum Data Set Coordinator / Registered Nurse) stated that R49 medical diagnosis includes convulsion, it was included on alteration of neurological status but not included on the fall care plan. When asked about R49's ADL (Activity of Daily Living), how does R49 do with bed mobility, transfers, and ambulation? V20 stated that R49's care plan for transfers and ambulation was not continued. V20 said after reviewing R49's care plan, It was not in the care plan. It does not have to have one. V20 stated that per MDS (Minimum Data Set) assessment, R49 needs extensive assistance. On 06/12/2024 at 03:16 PM, V11 (Licensed Practical Nurse) stated that when she did her rounds R49 was found on the floor. When asked about R49's ADL status on transferring, ambulation, and toileting. V11 said R49 was able to get up and walk. She was able to walk and no limitation going to the bathroom from her bed. On 6/13/2024 at 10:06 AM, V4 (Medical Doctor) stated that there is a collaboration of Hospice and Family. In cases of pain that cannot be controlled we need to intervene, do X-Ray, surgery, or other intervention for comfort reasons. Per facility incident report investigation dated 1/25/2024 document as follows: R49 was only oriented to self. Under predisposing factors: R49 was confused, incontinent, gait imbalance, impaired memory, non-compliant, weakness/ fainted. Under predisposing situation factors: R49 did a room change, wanderer, ambulating without assist, and that R49 cannot retain safety education, requires maximum supervision at all times for safety. R49 second fall dated 1/26/2024 was not included in the incident report. Per V26 (Certified Nursing Assistant) handwritten document included in the incident report, documents that R49 was seen on the floor. Per V26, R49 gets up with little help or no help. V26 full handwritten notes reads: I (V26) walk to room. R49 laying down on floor on left side with pillow under her head. Did not complain about pain. R49 get up with little or no help. On 6/14/2024 at 9:36 AM, V25 after reading the handwritten document that reads: V26 called me asking for help. When I walked in the resident was laying on her left side with a pillow under head. Nurse on duty was informed (V25 signature). V25 verified that it was her handwriting and both she (V25) and V26 wrote in the same piece of paper and gave it to V10 (Licensed Practical Nurse). V25 stated that R49 was confused and has an impaired gait. And that R49 needs supervision at all times. And that V26 was the certified nursing assistant that was assigned to R49 which per the same handwritten note, R49 get up with little to no help. R49's Admission Evaluation dated 1/24/2024, documents that R49 was at risk of fall, at risk of elopement, and has ADL (Activities of Daily Living) deficits on self-care, mobility usual performance that needs to be addressed in the care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R49's Minimum Data Set (MDS) assessment on functional dated 1/29/2024 documents that R49 needs substantial or maximal assistance means helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort on all ADLs (Activities of Daily Living) including bed mobility, sit to stand, transfers, and ambulation. R49's care plan dated 1/24/2024 identified R49 of having ADL (Activities of Daily Living) self-care and mobility usual performance deficit. The goal is to improve R49's level of function. But all interventions listed including transfers, positioning, bed mobility were left blank. Although R49 was assessed as elopement risk on admission evaluation (1/24/2024). And was identified as wanderer in the incident report. ADLs and elopement/wandering was not addressed in the care plan of R49. On 1/31/2024, R49 was admitted to the hospital. Per hospital records, R49 sustained left leg fracture. Per R49's X-Ray report done in the hospital dated 1/30/2024 it was documented that R49 sustained an acute displaced and angulated fracture of the left femoral neck. Left femoral neck location is at the top of the thigh bone. The area where R49 was complaining of severe pain. Facility policy on Fall Prevention and Management dated 6/1/2023 reads: Per CMS definition Fall refers to unintentionally coming to rest on the ground, floor, or other lower level. When a resident is found on the floor, a fall is considered to have occurred. Under evaluation, a baseline care plan is developed on admission by the Licensed Nurse based on the Morse Fall Scale result, resident/family input, medical condition of the resident per assessment. Under actions following a fall includes the following: Ascertaining if an injury has occurred and providing treatment as necessary. Addressing the factors for the fall. Under supervision, the facility will provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency based on the individual resident's assessed needs and identified hazards in the resident environment.