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	08/29/2024

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on interview and record review, the facility failed to meet personal care and nursing needs; and failed to ensure that a resident received treatment and care in accordance with professional standards of practice and in accordance with the resident's goals of care for one resident (R1) in a total sample size of three residents. Findings include: Facility's undated investigation form documents in part, At this time, it appears that V7 did not do appropriate rounding, nor did V7 make appropriate inquiries about the care needed for R1. V7's time sheet shows a late arrival to V7's shift. V7 also did not inquire about R1's needs from the nurse on duty. On 08/27/24 at 11:38am, V7 Certified Nursing Assistant (CNA) stated, I (V7) didn't get any report about R1. I (V7) didn't know that R1 needed help or assistance with feeding or being cleaned. I (V7) helped clean R1 when R1's daughter came. Before that I (V7) didn't clean R1 because I (V7) didn't think R1 needed me to do anything. When I (V7) cleaned R1 with R1's daughter, I (V7) realized that R1's wounds were exposed with no dressing on. I (V7) didn't notice any stool inside the wounds but R1 had no bandages on any of the wounds. R1 also had no diaper on. R1's daughter applied the bandages to the wounds. Now they (facility) are telling me (V7) that I (V7) neglected R1. R1's physician order dated 08/21/24 documents in part, Needs 1 to 1 assistance with feeding at every meal/snack. R1's care plan dated 08/18/24 documents in part, R1 has an ADL self-care and mobility usual performance deficit related to poor mobility, incontinence, end of life stages .Will manage ADLs to maintain comfort/dignity during end of life stages .Eating: substantial to dependent with 1 staff assist .Personal hygiene assistance level: substantial to dependent with 1 staff assist .Roll left and right: substantial to dependent with 1-2 staff assist .Toileting hygiene: substantial to dependent with 1-2 staff assist. R1's eating task flowsheet Setup or clean-up assistance- Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity documents yes for R1 on 08/20/24, 08/21/24 and 08/22/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 08/18/24 documents in part, The resident has bowel incontinence .check resident every two hours and assist with toileting as needed .Provide pericare after each incontinence episode. R1's medical diagnosis includes but are not limited to Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease without Heart Failure, Rheumatoid Arthritis, History of Falling, Pressure Ulcer of Right Hip Stage 3, Pressure Ulcer of Right Upper Back Stage 4, Pressure Ulcer of Left Upper Back Stage 4. R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 9, which indicates R1 has moderate cognitive impairment. R1's assessment for eating, toileting and personal hygiene are all documented as dependent, which indicates helper does all the effort, resident does none of the effort to complete the activity. R1's nursing progress note dated 08/22/24 documented by V14, Registered Nurse (RN) documents in part, Patient is very contracted and has three sores. dressing sores as ordered. Turning patient every 2 hours. On 08/27/24 at 1:13pm, V9 (CNA) stated, R1 could not reposition herself. R1 was contracted and couldn't move at all. On 08/27/24 at 2:58pm, V10 Registered Nurse (RN) stated, I (V10) do remember admitting R1 and R1 had wounds. R1 was very limited with movement and needed a lot of assistance. R1 was incontinent of bowel and bladder. R1 required assistance with feeding. I always get report to find out who has wounds and I stress to the CNA the importance of letting me know if a wound bandage is soiled. On 08/27/24 at 3:26pm, V12 (R1's family member) stated, I (V12) went to R1's room at 8:45pm on 08/20/24 and the door was completely closed so I (V12) knocked on the door assuming R1 was receiving incontinence care. As I (V12) looked at R1, I (V12) noticed that R1 had food all over R1 and was drenched in sweat. I (V12) told the staff that R1 was a feeder and had told staff that before R1 even came to the facility. V3 (RN) told me (V12) that V3 had no recollection of R1 having wounds. V7 told me (V12) that V7 did not get a report on the residents. When I (V12) pulled out R1's bedside table I (V12) noticed R1 had no diaper on, just a pillow between R1's legs and it was soiled with urine and feces. There was food visible on R1's face, R1's sheets and even on R1's headboard from R1 trying to attempt to feed R1's self. On Sunday when R1 arrived, I (V12) gave report to the charge nurse about how often I (V12) change the wounds and what I use to change the wounds. R1 had 3 wounds, when I (V12) arrived at the facility, R1's wound to the sacrum had a sponge over the wound that was full of blood. R1's other two wounds were not covered. When I (V12) saw that R1 was naked, I (V12) immediately told the CNA to get the nurse. When V3 came in V3 said that V3 had no knowledge of R1's wounds. R1 was contracted and could not feed R1's self or reposition R1's self. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 3:48pm, V13 CNA stated, R1 was a feeder. R1 was contracted. The day I (V13) had R1, I had to change R1 and I (V13) repositioned R1 and noticed a big wound on R1's hip. The area was raw and sore without a bandage, so I (V13) put a dry bandage over the reddened area. On the date of the incident 08/20/24 around 8pm, I(V13) heard a lot of commotion, so I (V13) went to check what was going on. The nurse told me that R1's daughter was yelling about another resident in R1's room and R1 naked with no diaper. I (V13) asked R1 if R1 was okay and R1 said no. At that time, I (V13) noticed a lot of open wounds on R1. V12 said that when V12 came in R1's room that R1 didn't have a diaper on. V12 allowed me (V13) to assist V12 with cleaning R1. R1 was on a regular mattress. On 08/28/24 at 10:30am V3 RN stated, R1 had wounds on R1's body. I (V3) was starting the before bedtime medication pass. V12 came to R1's room and found a male resident in the room and asked why the male resident was there and why R1 didn't have a diaper on. V12 questioned me (V3) on why R1 was dirty and V12 stated that R1's wounds needed to be changed. When I (V3) came in R1's room, V12 was cleaning R1 and I (V3) didn't see if the wounds were covered or not, the wounds were already exposed. R1 did not have an incontinence brief on when I (V3) walked in the room. The CNAs can always come and ask the nurse about a resident. Rounds are done every 2 hrs. R1 was not able to reposition self. R1 was not able to feed self, R1 needed assistance. The CNA (V7) did not assist R1 with feeding, V7 thought that R1 could feed R1's self. R1's arms were slightly contracted. R1 was incontinent of bowel and bladder. Diapers are placed on incontinent residents. R1 should have had a diaper on. R1 should have been assisted with R1's meals. For all PRN (as needed) wounds, if I (V3) visually see the wounds are soiled or if the CNAs do their rounds then the CNAs would let the nurse know the wound needs to be changed. I (V3) assumed that the CNA knew R1's status and would reposition R1. I didn't tell the CNA about the resident because I (V3) thought that V7 knew what to do for the resident. On 08/28/24 at 1:45pm, V2 Assistant Director of Nursing (ADON) stated, The facility's expectations is that the nurses should communicate with the CNAs to let the CNAs know what is going on with the resident and also a CNA handoff report should be done. The CNA's have to do frequent rounds on total care residents and if a resident is a high fall risk. 5 hours without checking on an incontinent resident is not acceptable; it should be at least every hour. If a CNA finds a soiled wound dressing that information should be communicated to the nurse right away to make sure that the wounds are clean and redressed. Diapers are for most of our residents who are incontinent. Facility's position description for Certified Nursing Assistant (C.N.A) dated 05/01/24 documents in part, I. Position Summary: Provides certified nursing assistant services to assigned residents in accordance with care plans, community policies and procedures and at the direction of supervisors .II. Key Duties and Responsibilities: 2. Assists residents with or performs activities of daily living for resident in accordance with care plans and established community policies and procedures .3. Assist resident with lifting, turning, transferring, positioning and transporting .6. Delivers nutritional supplements to residents at assigned times and provides resident assistance as needed to ensure intake .III. Essential Functions: 2. Treats residents, families, visitors and associates with dignity and respect. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's position description undated for Registered Nurse (RN) documents in part, Position Summary: Provide direct nursing care to the residents and supervises the day-to-day nursing activities performed by the licensed practical/vocational nurse and certified nursing assistants in accordance with current federal, state, and local regulations and guidelines and established facility policies and procedures .I. Key Duties and Responsibilities: Ensures that policies and procedures are complied with by nursing personnel assigned . Performs rounds to ensure resident needs are being met and personnel are performing their assigned duties. Facility's policy titled Activities of Daily Living (ADLs) dated 12/01/23 documents in part, Policy: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .Procedure: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .c. Elimination (toileting). Facility's policy titled Routine Resident Checks dated 07/2013 documents in part, Policy Statement .Staff shall make routine resident checks to help maintain resident safety and well-being .Policy Interpretation and Implementation .2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. Facility's policy titled Perineal Care dated 2021 documents in part, Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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F 0689 Level of Harm - Minimal harm or potential for 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** 41611 Based on observation, interview, and record review the facility failed to provide adequate supervision for one resident (R2). This failure affected one resident (R1) and has the potential to affect all residents residing on the 3rd floor. Findings include: R1 has a diagnosis of but not limited to Chronic Obstructive Pulmonary Disease, Hypertensive Heart, Rheumatoid Arthritis, History of Falling, Pressure Ulcer of Right Hip, stage 3, Pressure Ulcer of Right Upper Back, Stage 4, Pressure Ulcer of Left Upper Back, Stage 4. R1 has a Brief Interview of Mental Status score of 09. R2 has a diagnosis of but not limited to Dementia, Hypertensive Heart Disease, Dementia, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Anxiety Disorder. R2 has a Brief Interview of Mental Status score of 04. R2's Minimum Data Set, dated dated dated [DATE] documents, in part, Sit to Stand: Substantial/Maximal Assistance (Helper does More Than Half the effort), Chair/bed to chair transfer: Partial/Moderate assistance (Helper does Less Than Half the effort), Functional Limitation in Range of Motion: No impairment in upper and lower extremities, Mobility Devices: manual wheelchair. On 8/26/2024 at 3:23pm, surveyor observed R2 wheel himself into the CNA (Certified Nurses Assistant) charting area. Surveyor observed R2 wheel himself down the hall, on the high-end side (309-318) and back to the middle area twice. On 8/26/2024 at 3:24pm, V5 (CNA) stated R2 is a wanderer, and he does wander into other resident's rooms. On 8/26/2024 at 3:15pm, V7 (CNA) stated that R2 does wander around the unit in his wheelchair and that he did remove R2 from R1's room on 8/20/2024. V7 stated that R2 was sitting in his wheelchair on the left side of R1's bed, facing the window, with his pants down to his knees and that his incontinence brief was visible. Progress noted dated 8/20/2024 at 11:35pm by V3 (Registered Nurse) documents, in part, aide (V7) notified writer (V3) that V12 (R1's family member) found another resident (R2) inside resident's room. On 8/26/2024 at 3:37pm, V6 (RN) stated that R2 is a wanderer and that R2 sometimes wanders into other resident's rooms, but then he (R2) comes out on his own before he (V6) must go get him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/2024 at 3:14pm V11 (Plant Operations Supervisor stated camera for view of hallway 301-308 does not work. Surveyor reviewed another camera view from the CNA's charting area but V11 could not retrieve the data for August 20, 2024. On 8/27/2024 at 3:26pm, V12 (R1's Family Member) stated when she (V12) went to R1's room at 8:45pm the door was completely closed, so she (V12) knocked on the door assuming R1 was receiving incontinence care but when she (V12) entered, she (V12) saw R2 sitting on the side of her (R1) bed with his (R2) pants down. I grabbed the wheelchair handle and asked R2 who he was and what he was doing there. R2 stated his name and that he was trying to give her (R1) something because she won't eat. I went back out and found the CNA (V7) and had V7 to remove the resident from my mom's room. V7 stated that R2 goes in everybody's room. V12 stated that R2 said, I am trying to give R1 some sugar, as he threw a sugar packet on her over the bed table, but R1 won't eat. On 8/28/2024 at 10:29am, V3 (RN) stated that R2 had been removed from R1's room when she entered R1's room and that we (nursing staff) did not see R2 enter R1's room. On 8/28/2024 at 2:27pm, V2 (Assistant Director of Nurse-ADON) stated potential issues that could arise from the breakdown of supervision for a wanderer and other residents is that they (wanderer) can elope, get hurt or fall. R1's care plan focus dated 8/21/2024 documents, in part, assure the resident that she is safe and secure and assure her that needs will be addressed by trained caregiver. R2's Care plan focus for elopement documents, in part, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books and provides structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Resident Rights for People in Long Term Care Facilities, documents, in part, your right to safety: your facility must be safe. Undated policy titled Safety and Supervision of Residents documents, in part, our facility strives to make the environment as free from accident hazards as possible and resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Position Description titled Certified Nursing Assistant with an effective date of 5/01/2024 documents, in part, follows appropriate safety policies/procedures at all times to protect residents. Undated Position Description titled Registered Nurse documents, in part, promotes and protects all residents' right, follows appropriate safety measures at all times to protect residents.