

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  07/09/2025
NAME OF PROVIDER OR SUPPLIER  St Joseph Village of Chicago		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to implement interventions consistent with a resident's needs and current professional standards of practice to eliminate the risk of a fall for one (R1) resident out of six residents reviewed for quality of care in a total sample of six. This failure resulted in R1 sustaining a fall without significant injury.</p> <p>Findings include:</p> <p>On 07/08/2025, at 1:23 PM, V3 (Certified Nursing Assistant/CNA) stated that she was the assigned CNA for R1 when R1 fell on [DATE]. V3 stated that V3 was going around taking blood pressures and meal tickets. V3 stated I went to his room and he needed something. I told him to give me a second. I am going to take vital signs. I will be right back. At that time he kept getting up and I instructed him to lay back down, and he followed that command. I went to go get another resident's vital signs. When I came to his room, I heard him yell. I heard him say hey. When I looked in his room he was on the ground. V3 stated that R1 had a bump/knot/bruise on the left side of his head. V3 stated that R1 didn't have any other visible injuries, lacerations, or cuts. V3 stated that R1 did voice that he hit his head, but his head was not hurting. V3 stated we asked him these questions, but he was cracking jokes. We sat him up, and put him in our hallway. I fed him dinner before he went to the hospital. While he was waiting for the ambulance, he was doing fine. V3 stated that R1 was a fall risk and staff had to redirect him to use his call light. V3 reported that R1 was a one person assist and V3 would use a sit to stand mechanical lift for R1. V3 stated that R1 was incontinent but he liked to go to the bathroom for continence of bowel. V3 stated he (R1) wanted to get something; I cannot remember specifically. It is probably something he didn't have in the room, and I had to go get. I don't remember at this time what it was. V3 stated that when nursing assistants come on shift, they are required to get all vital signs under their care and get dinner orders by a certain time. V3 stated that R1 was responsive but he had moments and required a lot of redirections. V3 stated maybe he could have forgotten or gotten impatient. V3 stated that she did ask R1 for patience because V3 must have vital signs and dinner order information within the first hour. V3 stated that she told R1 that she would be back. V3 stated that she went to take three more residents' vital signs. V3 stated that it was not even five minutes that went by when she checked on R1. V3 stated I think he got antsy and forgot what he asked me for. If I would have found him 10 to 15 minutes later, it would have been worse. It was probably something he wanted a new container. That is why I told him one second, I'm going to take vital signs.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2025, at 1:46 PM, V4 (Registered Nurse) stated R1 has left side weakness and R1 is usually redirectable. V4 stated that R1 told V4, R1 knows he should have not touched his feet. I think he leaned down and he lost his balance. Since he couldn't move his left side, he did not have a chance for support. V4 stated that she didn't know R1 was asking for something. If the resident needs something, they should attend to it. If the CNA needs help, they can ask the nurse for help. V4 stated that R1's fall prevention interventions included reminding R1 frequently to call us for help, give him the call light, bed at lowest position, putting safety floor mats, and doing frequent rounds because sometimes he wants to do something on his own.</p> <p>On 07/08/2025, at 3:30 PM, V2 (Director of Nursing) stated in a perfect world, I would have gotten what R1 wanted. I understand that not fulfilling his needs can lead to a fall. It was not emergency, she was strictly just doing a routine task. V2 stated that attending to resident's needs are number one although vital signs are a critical part of patient care because the residents are getting ready to receive the evening medications.</p> <p>R1's face sheet documents that R1 is a [AGE] year-old individual with diagnoses not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unsteadiness on feet, muscle weakness (generalized), unspecified symptoms and signs involving cognitive functions following cerebral infarction, difficulty in walking.</p> <p>R1's care plan documents in part R1 is at risk for falls and fall related injuries r/t (related to) unsteady balance, left hemiparesis status post-acute stroke right middle cerebral artery distribution infarction. R1 will be free of falls and fall related injuries daily through next the review date.</p> <p>The resident needs prompt response to all requests for assistance.</p> <p>R1's incident note dated 6/6/2025, at 7:00 PM, documents in part resident (R1) was observed lying on prone position on the floor between the bed and the window side. A lump was noted on the left side of the forehead. The resident is able to move his right extremities. The left side is paralyzed as baseline.</p> <p>R1's health status note dated 6/6/2025, at 10:00 PM, documents in part placed call to hospital ER (emergency room) and confirmed that the resident was there. All tests were negative. Nurse in charge stated also that resident will be back to facility within the next few hours.</p> <p>Facility document dated 10/23/2024, documents in part fall prevention &amp; management policy. Fall prevention is achieved through an interdisciplinary approach of education, managing risk factors, and implementing appropriate interventions to reduce the risk of falls.</p> <p>Facility document not dated titled resident rights documents in part the resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p>		