

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6016752</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VICTORIAN VILLAGE HLTH &amp; WELL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12525 W RENAISSANCE CIRCLE HOMER GLEN, IL 60491</b>
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S 000	Initial Comments  Annual Licensure and Certification Survey.	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.1210d)6) 300.3240a)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.  Section 300.1210 General Requirements for Nursing and Personal Care  b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999		

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>07/18/17</b>
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S9999	<p>Continued From page 1</p> <p>each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to implement fall prevention / safety measures including the use of chair alarms, locking wheel chair wheels for residents that were high risk for falls.</p> <p>This applies to 2 of 2 residents (R2 and R7) reviewed for falls with fracture in a sample of 12.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>As the result of this failure, R2 sustained impacted acute fracture of the distal radius.</p> <p>The Findings include:</p> <p>On June 20, 2017 at 11:00 AM, R2 was in the wheel chair seated at a table, stationed in the dining room. R2 was quiet, had R2's right hand over R2's left shoulder with grimace on face, R2 was unable to express verbally of any pain.</p> <p>R2's admission (September 16, 2016) nursing fall assessment showed a score of '18' meaning R2 is at high risk for falling due to the history of recent fall with a left shoulder fracture, confusion, require one to two staff members and is chair bound. R2's subsequent quarterly fall assessment also showed a score of '18' and R2 continued to be at high risk for falls.</p> <p>R2's October 5, 2016 high fall risk care plan interventions included: keep bed in the lowest appropriate position and to use chair alarm.</p> <p>The Facility's Nurses notes for April 2017 and facility's incident reports showed on April 10, 2017 at 7:30 AM E13 (Resident Care Partner / Certified Nurse Aide - CNA) noted R2 had discoloration to left upper inner arm while performing activities of daily living and reported to E8 (Day Nurse). E8 along with E14 (Night Nurse) conducted assessment of the injuries and noted 3.0 cm x 5.5 cm hematoma to left upper inner arm, mild hematoma and 1+ swelling to left wrist and 3.0 cm / 0.75 cm abrasion to the left elbow and the range of motion to left wrist was guarded.</p> <p>R2's April 10, 2017 X-Ray report showed R2 sustained impacted acute fracture of the distal</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>radius. R2's April 10, 2017 Emergency Department physician notes read 'patient presents following fall and was sent from the nursing home for fracture of the left distal radius.'</p> <p>The facility incident investigation report did not determine how R2 sustained the injuries on April 10, 2017. No changes in the plan of care interventions were made. The staff interviews conducted during the investigation, none of the staff was able to state how R2 sustained fractured left wrist.</p> <p>According to staff schedule pattern, there is only one CNA for each independent house at night shift. Based on the lay out of the House, it is not practical for one staff to have a full visual view of the residents' movements, answer call lights and attend to residents' nursing needs. There is only one Nurse between two independent houses.</p> <p>R2 after sustained injuries including left wrist fracture on April 10, 2017, R2 had three accidents / incidents:</p> <p>On April 18, 2017 at 8:00 PM, R2 was found on the dining room floor on R2's back. One of the residents who witnessed the incident 'R2 tried to reach out and pass candy to the other resident, as R2 keeps moving the wheel chair moved and R2 slid out of the wheel chair and landed on R2's buttocks on the floor.'</p> <p>On April 20, 2017 at Noon noted increased swelling of left hand where cast is in place for previous fracture. R2 was sent to Emergency Department. No specifics available to determine cause and effect of the injury. When R2 returned to the facility at 7:30 PM, R2 came with steristrips on the right shin. No details available to</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>determine how R2 sustained the skin tear on the right shin.</p> <p>During the survey from June 20, 2017 through June 23, 2017 R2 had no wheel chair alarm on, the wheel chair wheels were not locked when R2 was seated in her wheel chair. On June 22, 2017 at 2:30 PM an agency staff stated she was not aware R2 uses a chair alarm. R2's wheel chair was sliding away from the table as R2 attempted to turn self in the chair. On June 23, 2017 at 10:30 AM, one of the consultant staff verified R2's wheel chair was not locked while was seated in the wheel chair.</p> <p>2. R7's medical record documents R7 was admitted with the following diagnoses: Diabetes mellitus, congestive heart failure, clotting deficit, history of falls, hypertension, hypothyroidism, atrial fibrillation and bradycardia.</p> <p>The facility incident report documents the following falls for R7: Original admit: January 16, 2017. Fall on January 28, 2017-CNA (Certified Nursing Assistant) entered the room and observed resident on floor. Prevention measures at time of fall, Alarm (none); Resident reassessment prior to fall: Fall risk assessment (N/A); Plan of care for falls completed (N/A). Conclusion written by E2 (Director of Nursing) entered on March 22, 2017. Root cause- due to resident action or internal risk factor. Recommendation - none noted.</p> <p>Readmit: March 15, 2017. Fall on March 16, 2017 0345 am, Observed lying on floor, with legs out in front, wrapped in a blanket. Alert and oriented X 2 which is resident's baseline. Stated "I was getting up to go to the bathroom. Alarm</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>(none), Fall risk reassessment completed (N/A), Plan of care for falls completed (N/A). Staff interviews (No staff interviews available). Root cause-due to resident action or internal risk factors. Recommendations- none noted.</p> <p>There were no fall risk assessments in R7's medical record prior to the fall on March 16, 2017.</p> <p>On June 21, 2017 at 2:31 PM, R7 was alone in R7's room. R7's call light was not in reach. R7 was sitting in the wheelchair wearing a cervical collar. There was an alarm on R7's chair. The activation switch was in the off position. The indicator lights were not flashing. E9 (Certified Nursing Assistant) stated she was R7's care giver. When asked about the alarm, E9 turned the alarm on. The lights were now active. E9 stated "I'm not sure with the new alarms if the switch activates them or not."</p> <p>On June 21, 2017 at 2:47 PM, E10 (Certified Nursing Assistant) stated she was R7's care giver when R7 fell on March 16, 2017. E10 stated R7 was confused. E10 stated she did not know if R7 had falls prior to March 16th and R7 was not a fall risk. E10 added R7 received an alarm after the fall on March 16, 2017.</p> <p>On June 21, 2017 at 3:00 PM, E2 (Director of Nursing) stated R7 was initially admitted to the facility with a cervical collar related to a C2 fracture. E2 stated on March 16, 2017, R7 was attempting to go to the bathroom when R7 fell. E2 stated residents deemed high risk for falls are given a bed / chair alarm. E2 stated R7 was provided an alarm after the March 16th fall. When asked to provide R7's care plan prior to the fall, E2 looked in the computerized charting and stated "I don't see it." E2 stated R7 was totally</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>confused and had been taking muscle relaxers prior to the fall. E2 stated R7 should have been high fall risk and given alarm prior to the fall. E2 added that the facility does not have a Quality Assurance Committee. E2 stated there has been no individual review of R7's fall / interventions. E2 stated when staff hear alarms they go there to try to prevent falls. E2 stated alarms should be on whenever residents are up and in their chairs.</p> <p>The Care Plan documents: at high risk for falls - March 16, On floor, initiate bed alarm. June 13, 2017- did have a fall and may need surgery on the C2 fracture.</p> <p>The radiology report for R7 dated March 16, 2017 documents: In comparison to report March 5, 2017 - Redemonstrated is a C2 fracture with 2.5 mm posterior displacement of the cephalic fragment.</p> <p>The physician progress notes dated March 17, 2017 documents: The x-ray does not look good as there seems to be an offset that has happened since the x-ray about ten days ago and so the fall probably did not help. I suspect we are now looking at a surgical option rather than hoping this fracture is going to heal.</p> <p>The policy for Falls Reduction documents: The facility's clinical team reviews falls at least weekly to attempt to discern a root cause. This process includes the evaluation of factors such as medications, toileting patterns, infection, etc to recommend new prevention strategies.</p> <p>Results of the fall committee review are communicated to staff through written updates to the client care plan and verbal communication during shift to shift report.</p>	S9999		
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