STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **145029**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **03/11/2020**

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

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist a resident identified as needing assistance with oral care and personal hygiene. This applies to 1 of 3 residents (R2) reviewed for oral care and personal hygiene in the sample of 5. The findings include: R2 was admitted to the facility on [DATE]. R2 has multiple [DIAGNOSES REDACTED]. R2's annual MDS (minimum data set) dated 2/12/2020 shows that the resident is cognitively intact and would require extensive assistance from the staff with regards to personal hygiene. The same MDS also shows that R2 does not have any oral/dental concerns. On [DATE] at 11:48 AM, R2 was sitting in his wheelchair inside his room. R2 was alert, oriented and verbally responsive. V3 (CNA/Certified Nursing Assistant) removed R2's socks and shoes. R2 had a strong foot odor. R2 had an unpleasant odor coming from his mouth when he talks. R2's tongue was noted with crusted whitish substances and the resident had missing/broken teeth. According to R2 no one cleans his mouth. R2's fingernails were long, jagged and with black substances underneath. V3 was present during these observations. R2's physician order [REDACTED]. R2's care plan shows that the resident requires staff assistance for all ADLs (activities of daily living). The same care plan shows multiple approaches which included, Perform adl's (activities of daily living) as needed for resident. On 3/10/20 at 11:55 AM, V2 (Director of Nursing) stated that it is part of the nursing care and service to assist and/or provide oral care, foot care and trimming/cleaning of residents' fingernails.
F 0687 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident receives foot care and treatment for [REDACTED]. This applies to 1 of 3 residents (R2) reviewed for foot care and services in the sample of 5. The findings include: R2 was admitted to the facility on [DATE]. R2 has multiple [DIAGNOSES REDACTED]. R2's annual MDS (minimum data set) dated 2/12/2020 shows that the resident is cognitively intact and would require extensive assistance from the staff with regards to personal hygiene. On [DATE] at 11:48 AM, R2 was sitting in his wheelchair inside his room. R2 was alert, oriented and verbally responsive. V3 (CNA/Certified Nursing Assistant) removed R2's socks and shoes. R2 had a strong foot odor. R2's toenails were long and curling (curling under the toe) with thick bilateral great toenails. R2's foot had dried flaky substances and was noted with black discoloration on the skin directly above the right second toenail. R2's physician order [REDACTED]. R2's physician order [REDACTED]. R2's electronic records from his most recent readmission to the facility on [DATE] through [DATE] shows no evidence that the resident was evaluated and/or treated by the podiatrist. On [DATE] at 2:40 PM, V1 (Administrator) stated that he reviewed R2's paper and electronic records from admission (2/19/2019). According to V1, the facility cannot find any records to indicate that R2 was evaluated and/or treated by the podiatrist since admission. On 3/10/20 at 9:07 AM, V1 stated that the podiatry office does not have any record that R2 was seen at the facility since admission on 2/19/19. On 3/10/20 at 12:10 PM, V8 (Podiatrist) stated that she evaluated and treated R2 that morning. V8 stated that R2 had long toenails that required trimming. R2's toenails had fungal infection and the resident's foot was very dry.

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

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.