STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006720	A. BUILDING: _____ B. WING _____	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK BROOK CARE	2013 MIDWEST ROAD OAK BROOK, IL 60521

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S 000	Initial Comments Complaint Investigation 1973852/IL112566 1973902/IL112622 1974005/IL112727	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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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:

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.

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)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure a safe, obstacle-free dry environment for a resident transfer and failed to assist a resident's request for toilet use in a timely manner.

This failure resulted in R1 tripping over a towel and sustaining a hip fracture, requiring surgical intervention.

This applies to 2 of 3 residents (R1, R3) reviewed for falls with injury in the sample of 3.

The findings include:

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1. The EMR (Electronic Medical Record) shows R1 was readmitted to the facility in August 2018. R1 was discharged to home on November 20, 2018 and no longer resides at the facility. R1 had multiple diagnoses including, right femoral neck fracture, presence of right artificial hip joint, hypoglycemia, chronic ischemic heart disease, fracture of the sacrum, history of falling, chronic pain, depressive episodes, lupus, nausea with vomiting, weakness, lack of coordination, abnormal gait and mobility, anemia, rheumatoid arthritis, aphasia following cerebral infarction, recurrent CVA (Cerebrovascular Accident) with right-sided weakness, gastrostomy tube, and atrial fibrillation.

R1's MDS (Minimum Data Set) dated September 10, 2018 shows R1 had severe cognitive impairment, was totally dependent on two facility staff members for transfers and toilet use, required extensive assistance with bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene, and bathing. R1 was frequently incontinent of urine, and always incontinent of stool.

The facility's fall risk assessment dated September 27, 2018 shows R1 was a high fall risk.

The facility's Incident Report dated October 4, 2018 shows: "On 10/2/2018 at 7:37 PM, assigned CNA (Certified Nursing Assistant) (V4) reported to nurse on duty that resident had a fall incident. Nurse on duty immediately went to resident's room. Resident noted lying in a supine position on the floor with both arms and legs extended, near the right side of bed. Locked shower chair behind resident and platform walker on the side of the

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resident. Room was well-lit and clutter free. A towel was placed on floor as resident had just been given a shower. On assessment, resident able to do usual movements of both upper and lower extremities. No new bruises, skin tears, cuts, abrasions or skin issues noted. Resident alert, oriented x 3, verbally responsive. Denies any pain or discomfort. Denies hitting her head or any other body part. Denies headache, dizziness or light-headedness. Per resident, she was transferring from the shower chair to the bed when she slipped on the towel."

R1's Incident Report dated October 4, 2018 shows R1 did not complain of pain on October 2, 2018. R1 complained of pain on October 3, 2018. Physician orders were obtained on October 3, 2018 for X-rays of the right hip/pelvis, which showed an acute or subacute subcapital fracture with mild superior displacement of the distal fracture fragment.

Hospital documentation shows R1 had a right hip hemiarthroplasty surgery on October 5, 2018.

On June 4, 2019 at 1:10 PM, V2 (DON/Director of Nursing) said, the shower chair was used as a transport device for R1 from the shower to R1's room. V2 said the facility's shower chair can act as a transfer device and a shower chair. V4 (CNA) was alone and attempted to transfer R1. The incident report shows R1 fell over a towel that was placed on the floor. V2 said, "The towel should not have been there. [V4] made the decision because the floor was wet and she put the towel there to dry the floor. The cause of the fall was the towel. The resident had a history of a CVA and had severe cognitive impairment as shown on the MDS. The CNA should have been using a gait belt but the CNA said the resident

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was naked and she did not apply the gait belt to the resident because she didn't have clothes on. The CNA wanted to apply the clothes prior to using the gait belt but never got the chance."

On June 4, 2019 at 2:44 PM, V4 (CNA) said due to the length of time that had passed since the incident, she could not recall any specifics related to the incident and her written statement to the facility would be more accurate than an interview at this time. V4's written statement dated October 2, 2018 shows V4 was alone in the room with R1 and the resident fell over a towel after her shower was given. V4 said in her statement: "[R1] was standing up, moving to the bed, [V4] had just given shower. [R1's] feet were wet, so towel was placed on floor to keep from slipping on floor. As [R1] moved, foot got tripped on towel, patient went down slow."

On June 4, 2019 at 3:05 PM, V6 (Director of Therapy) said, R1 initially required a mechanical lift device for transfers but was upgraded to a one person, moderate assist with transfers on September 28, 2018. V6 said R1 also used a platform walker. V6 said, "Therapy recommendations to residents and facility staff are based on the fact the environment has been determined to be safe and free of water or obstacles such as towels."

On June 4 2019 at 4:53 PM, V5 (Physician) said R1 was at an extremely high risk for falling. V5 said, "The fall definitely caused [R1's] fracture, resulting in the need for surgical repair. As a healthy person, I know I would not trip over the towels on the floor but she had a lot of medical problems." V5 said the combination of R1's medical condition and the towel on the floor caused R1's fall.

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The facility's Fall Prevention Policy dated September 2015 shows: "Policy: This facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident's fall is not possible, it is this facility's policy to act in a proactive manner to identify and assess those residents as risk for falls, plan for preventive strategies, and facilitate a safe environment as possible."

The facility's Accident Prevention and Resident Supervision Policy, dated September 2015 shows: "Policy: This facility ensures to provide an environment that is free from hazards over which the facility has control and provides appropriate supervision and assistance devices to each resident to prevent avoidable accidents. This includes systems and processes designed to: 1. Identify hazards and risks; 2. Evaluate and analyze hazards and risks; 3. Implement interventions to reduce hazards and risks; and 4. Monitor for effectiveness and modify approaches as indicated; 5. Residents receive supervision and assistive devices to prevent avoidable accidents. Avoidable Accident means that an accident occurred because the facility failed to: Identify environment hazards and individual resident risk of an accident, including need for supervision; and/or evaluate/analyze the hazards and risks; and/or Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident."

2. The EMR shows R3 was recently readmitted to the facility on May 21, 2019 with multiple diagnoses including right femur fracture, history

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of falling, encephalopathy, acute respiratory failure, altered mental status, chronic viral hepatitis C, chronic obstructive pulmonary disease, anemia, hypertension, epilepsy, alcoholic cirrhosis of the liver, and emphysema.

R3's MDS dated May 28, 2019 shows R3 is cognitively intact, is able to eat with supervision, requires limited assistance with personal hygiene, and requires extensive assistance by facility staff with bed mobility, transfers between surfaces, locomotion on and off the unit, dressing, toilet use, and bathing. R3 is occasionally incontinent of urine and always continent of bowel.

R3's POS (Physician Order Sheet) dated June 5, 2019 shows R3 takes multiple medications including Lactulose 20 grams orally every 6 hours for her liver cirrhosis, Spironolactone (diuretic medication) 50 mg. orally every day for her hypertension, and Xarelto (blood thinner) 10 mg. orally every day.

On June 5, 2019 at 9:35 AM, R3 was sitting in the wheelchair in her room. R3 had noticeable facial bruising around her bilateral eyes, nose, forehead and neck. R3 had a swollen area on her forehead over her left eye. R3 said she is only 25% weight-bearing due to a fall she sustained at home in May 2019 and she is residing at the facility to receive therapy services. R3 said, "On May 29, I used the call light to ask for help going to the bathroom, and the CNA came and turned it off and said she would return in a minute. A minute turned into longer so I tried to go by myself. I take Lactulose four times a day for my liver cirrhosis, and it makes me have frequent bowel movements. Unfortunately, I don't get a lot of notice. When the urge strikes me I have to go now! I also take a diuretic, so I have to urinate

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frequently and if I don't get into the restroom, I will wet myself. I had to go so bad. I thought my wheelchair was closer to me than it was. I got up to get my wheelchair and then I felt weak and fell. They sent me to the hospital. I didn't need stitches, but I'm on a blood thinner so I bled a lot from my nose. They did a CT scan on my head and neck. Luckily I didn't damage my new hip."

Hospital documentation dated May 29, 2019 for R3's CT scan of the brain shows, "prominent left frontal scalp hematoma, left frontal and periorbital soft tissue hematoma."

On June 5, 2019 at 9:51 AM, V7 (CNA) said, "I came into the building to start my shift at 7:00 AM on May 29. I was late that day. I saw [R3's] call light was on. I went in the room and turned off the call light. I told her to let me go punch in and check the schedule and I would be back. When I came back, they said she was on the floor and had fallen. I can't say exactly how much time had passed. I did not ask anyone else to help her when I turned off her call light. She is able to transfer herself from the wheelchair to the toilet, but she can't walk by herself."

The facility provided documentation to show they reviewed their security camera footage which showed R3 turned her call light on at 7:06 AM and V7 (CNA) entered the room at 7:07 AM, turned off the call light, and left the room. At 7:17 AM facility staff standing outside R3's room heard R3 calling for help and at 7:18 AM, CNAs and nurses came to the room to assist R3 after falling.

On June 5, 2019 at 12:43 PM, V2 (DON) said, "The facility does not have a call light policy. The staff is not supposed to turn off the call light until the need is met. The CNA should not have turned

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S9999	Continued From page 8 off [R3's] call light until she received the requested assistance." (A)	S9999		