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 12/06/2021

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 2178816/IL140728 Investigation of Facility Reported Incident of 11-26-21/IL140823	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to follow recommended techniques for turning residents in bed. This failure resulted in R2 sustaining a fracture during repositioning. The facility also failed to supervise a resident that requires extensive assistance for an extended period during use of the toilet. These failures affected 3 of 5 residents (R1, R2, R3) reviewed for safety and supervision during activities of daily living care in the sample of 6. Findings include: 1. R2's Face Sheet showed R2 is 98 years old with multiple medical diagnoses which include Osteoporosis, Bilateral Knee Osteoarthritis, Degenerative Joint Disease (DJD), Left Proximal Humerus Fracture status-post (s/p) Internal Fixation, history of Non-Displaced Acute Fracture of the Right Distal Fibular Shaft and Posterior Malleolus (6/11/20), fall at home with Right Femur Fracture s/p ORIF (Open Reduction Internal Fixation). Incident report showed: On 11/26/21 at 6:00 AM, V8 (Certified Nursing Assistant/CNA) was cleaning R2, changing incontinence brief in bed when R2 reported to V8 that she heard a pop sound as V8 was turning her. At 6:20 AM, R2 complained of left knee pain and was given a pain reliever. V4 (Physician) was notified with	S9999		

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S9999	Continued From page 2 order to do a STAT x-ray to left femur and tibia/fibula. X-ray was done. Left femur result showed acute sub-capital femoral neck fracture. The tibia/fibula x-ray showed generalized Osteopenia. R2 is alert and oriented, with episodes of forgetfulness, however, she can express her needs and discomfort. R2 requires assistance with activities of daily living (ADL) and mechanical lift with 2-staff assistance for transfer due to weakness. On 12/1/21 at 11:00 AM, R2 was resting in bed with a pained expression on her face. R2 appeared stiff while lying in bed and stated that she was in pain with a scale of 10 out of 10. R2 stated that on the day of the incident (11/26/21), V8 (CNA) was assisting her (R2) to position on her right side. V8 rolled R2 away from him during repositioning. V8 assisted to position R2 on her right side by pushing her on her left thigh. V8 did not touch her on any other part of her body during positioning except for her left thigh. As V8 was rolling her with his hand on her left thigh they heard a loud pop coming from her thigh. R2 told V8 that she hoped she didn't break a bone. R2 also said that she didn't feel pain initially, the pain started to creep a few minutes later in her left thigh going up to the groin until it became intense. R2 added that V8 was alone when he (V8) repositioned her. On 12/1/21 at 3:55 PM, R2 was asked the same question with regards to the incident that happened to her, R2 re-told the same story that she had said that morning. On 12/1/21 at 4:19 PM, V8 (CNA) stated that on 11/26/21, R2 needed incontinence care. V8 turned R2 on her side, towards him by supporting her on her right shoulder and right hip. When V8	S9999		

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S9999	Continued From page 3	S9999		

was asked which side of the bed he was standing, V8 said he was on the left side of R2's bed. V8 also said that he heard R2 said "Ow" while V8 was rolling her. V8 asked R2 was R2 was okay, and R2 said "yes." V8 then went to the other side (right side) of the bed to pull the soiled pad and incontinence brief from R2 while R2 was lying on her right side. V8 was alone when he repositioned R2.

During interview on December 21, 2021 at 11:25AM, V6 (Physical Therapy Assistant/ PTA) stated that residents with osteoporosis or brittle bones and requiring two-person assistance must be turned by supporting the resident through their major joints. These major joints would include the shoulder and hip. V6 continued to add that if only one person is assisting, then the resident should be rolled towards the staff to provide more control. V6 also stated that staff should not push residents in the thigh due to the possibility of injury.

On 12/1/21 at 1:20 PM, V3 (Rehab Director) gave the following statement: R2 requires 2 staff assistance for repositioning. One staff on each side of the bed - one pulling the resident towards them and one away from them as support. When you roll the resident on their side you support them in the major bone such as the shoulder and hip, another safe way is the use of draw sheet; the staff have wider range for the resident especially in the mid-body for safety alignment of body mechanics for both the resident and the staff. Given R2's history, R2 is more susceptible to fracture. It's possible that the improper positioning is the cause of fracture.

On 12/1/21 at 11:38 AM, V5 (Nurse Practitioner/NP) stated that osteoporosis,

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S9999	Continued From page 4	S9999		

osteopenia, and osteoarthritis are all weakening of the bones. V5 is not familiar on how staffs provide care for R2. However, the staff must follow whatever is recommended for R2 with regards to procedure on ADL (activities of daily living) care to prevent injury.

On 12/1/21 at 12:47 PM, V4 (Physician) stated that R2 is 98 years-old and it's natural that she has weakened bones. V4 was aware of the incident that happened to R1, V4 did not see the whole event but if indeed, V6 positioned R1 the way R1 described it, then yes, it could have possibly caused it. However, V4 concurred on what V6 said regarding safe positioning and whatever is recommended for R1 with regards to safety in ADL.

On 12/1/21 at around 4:50 PM, V2 (Director of Nursing/DON) stated staff should have followed the recommended assistance for R2 according to the care plan for safety.

On 12/2/21 at 12:50 PM, V15 (CNA) and V16 (CNA) both stated that they are familiar with R2 and her condition and they need to provide 2 staff assistance for R2's ADL care. One staff on each side of R2's bed since R2 has fragile bones and history of multiple fractures.

R2's MDS (Minimum Data Set) dated 9/27/21 showed that R1 is alert and oriented and requires two staff assistance for bed mobility.

R2's updated care plan (with target goal date of 1/24/22) showed that R2 has impaired bed mobility as evidenced by difficulty in repositioning self in bed. The goal for R2 is that she will be able to reposition self in bed with extensive assistance of two persons by next review.

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S9999	Continued From page 5 2. R3 is 76 years old with multiple medical diagnoses which include age related osteoporosis without pathological fracture, presence of bilateral artificial knee joints and presence of right artificial hip joint. MDS dated 9/22/21 showed that R3 requires extensive assistance by 2 staff for bed mobility and toileting. On 12/2/21 at 2:20 PM, V16 (CNA) and V20 (CNA) rendered incontinence care to R3. R3 appeared stiff in the lower extremities and was unable to move by herself. V20 turned R3 on her (R3's) left side towards V20 by pulling R3 in the right shoulder and right lower thigh, just behind the upper right knee. R3 was unable to sustain being on her right side and had poor trunk control. V20 kept R3 positioned on R3's left side by holding R3 on her right side (between the rib cage and the right hip) and upper thigh. R3's upper back was leaning backward while the lower back was positioned forward making her torso not properly aligned while positioned on her left side. Facility's Competency Test: Repositioning Resident in Bed documents: Practice proper body alignment with resident. Align resident safely in the center of the bed, away from the edge. 3. R1 is 99 years-old with multiple medical diagnoses which include abnormalities with gait and mobility, weakness, and bilateral osteoarthritis of the knees. R1's MDS dated 11/13/21 showed that R1 is alert and oriented and requires extensive assistance by 2 staff for toileting and transfer. R1's most recent fall risk assessment dated 11/10/21 showed that she is identified as a high risk for fall. During an interview of 11-30-2021 at 11:50AM,	S9999		

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S9999	Continued From page 6 V12 (R1's family) stated that on 11/19/21 (Friday) at around 6:30 PM, V12 called R1 multiple times, and she (R1) was not responding to V12's calls. V12 stated that R1 still was not answering call after 7:00PM, so V12 became worried and called and asked staff to check on R1. The staff (V12 was not able to identify who it was) found R1 sitting on the toilet. When the staff gave the phone to R1, R1 stated that she had been sitting on the toilet for about 45 minutes. V12 then requested to talked to the nursing supervisor (V9) about this concern and about R1 turning on the call light with no response. V12 was upset that no one checked on R1 until she called the facility. On 11/30/21 at 3:03 PM, V9 (Nursing Supervisor) stated that V7 (Licensed Practical Nurse/LPN) called V9 around 8:30 PM and reported that R1 was left on the toilet for about 45 minutes. V9 investigated the incident. V9 talked to R1 and R1 informed her (V9) that V10 (CNA) put her on the toilet and left her there alone for a long period of time about 30-40 minutes. V9 talked to V10 (CNA) and was informed that she assisted R1 to the toilet and left her there to assist another resident with a shower. V10 did not endorsed to other staff members that R1 was left in the bathroom. V9 counselled V10 that she was not supposed to leave any resident unattended on the toilet. V10 informed V9 that she was aware of it, but she lost track of the time. V10 was an agency CNA; she (V10) was not familiar with the residents in the 200 unit, so it took her a while to finish assisting the other resident with showering before she could go back to R1. On 12/1/21 at 11:25 AM, V6 (PTA) stated that he is familiar with R1's condition. R1 requires extensive assistance by two staffs. R1 should not be left alone sitting on the toilet. Staff should not	S9999		

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S9999	Continued From page 7 leave any resident alone for a long period of time in the bathroom. Thirty minutes is a long period of time. This can possibly cause discomfort to resident and if the resident who requires extensive assistance tries to get up on their own, it can cause a potential fall incident. (B)	S9999		