STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003032	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

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S 000	Initial Comments Complaint Investigations: 2272433/IL145139	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. 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	S9999		

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S9999	Continued From page 1 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 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced	S9999		

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S9999	Continued From page 2 by: Based on observation, interview and record review, the facility failed to provide safety measures for a resident while being turned /repositioned during provision of care. These failures resulted in R9 sustaining a fracture of the nose from a fall incident. This applies to 1 of 3 residents (R9) reviewed for high risk for falls. The findings include: The EMR (Electronic Medical Record) shows that R9, a 73-year-old, was originally admitted to the facility on February 11, 2022, was sent out to the hospital on 3/2/2022 due to lethargy and was readmitted back to the facility in 3/11/2022. R9 has diagnoses including hypotension episode, spinal stenosis, diabetes type II, congestive heart failure, hypertension, end stage renal disease and dependence on hemodialysis, pulmonary embolism, and hyperlipidemia. The progress notes by V3 (Attending Physician) dated 3/22/2022 shows detailed medical history of R9: "significant for hypertension, end-stage renal disease, anemia, history of uterine cancer, anxiety disorder who was admitted to the hospital with complaints of difficulty ambulating and severe pain in both lower extremities ... Hospital records reviewed initially had orders for imaging, patient however due to progressive pain went to the ER (Emergency Room) for further evaluation CT (Computerized Tomography) scan of the lumbar spine, demonstrated severe spinal stenosis therefore was admitted for pain control. Patient evaluated by nephrology service due to her end-stage renal disease, patient has been compliant with her dialysis ... Evaluated by hematology oncology service as patient has been	S9999		

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S9999	Continued From page 3	S9999		

on Eliquis (anticoagulant medication) but however has been developing clots ... However, patient was sent to the hospital (3/2/2022) due to her decline per daughter's request ... Now readmitted back to skilled nursing facility (3/11/2022) for rehab and care. Patient seen and examined, care reviewed with nursing staff, notified of patient will be out of bed while attempting to get on diet. Reported to have pain, had x-rays taken bilateral knees noted with arthritic changes with no fracture or dislocation. Also has pending x-ray of face, with nasal scrape. No complaints of respiratory distress no complaints of pain noted at this time ... Physical Exam: Vitals reviewed; HENT: Nose: Scrape at nasal bridge; Mental Status: She is alert and oriented to person, place, and time; Motor: Weakness present; ...Comments: Fall, mechanical in nature, while attempting to turn to the side x-rays of knees with no acute pathology facial x-ray pending."

The facial x-ray result dated 3/22/2022 shows that R9 had sustained fracture of the nasal bone.

The Fall Risk assessment dated 2/11/2022 shows that R9 had a score of 15, a high risk for fall (a score of 10 and more is considered a High Risk for Fall).

The MDS (Minimum Data Set) dated 2/18/2022 shows that fall risk was triggered for R9 for not being steady during turning and repositioning, requires extensive assistance for bed mobility, and toilet needs including use of bed pan. The toilet needs also includes the use of bed pan shows that R9 requires assistance of 2 plus staff. The MDS also shows that R9 has history of fall from the last 6 months.

The MDS dated 3/15/2022 shows that R9

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S9999	Continued From page 4 requires extensive assistance for bed mobility, and toilet needs including the use of bed pan. Again, R9 was assessed as needing assistance of 2 plus staff for using the bed pan. The CNA (Certified Nursing Assistant) documentation task for ADL (Activities of Daily Living) for the month of February through March 21,2022 shows that R9 requires extensive assistance for toileting needs. The progress notes dated 3/21/2022 at 10:48 A.M., shows that "(R9) had rolled onto the bed bolster and slid out of bed on to her right side while (R9) was getting onto the bedpan. ...(R9) had slid out of bed and onto floor. (R9) had no new pain due to fall; (R9) however, has chronic pain in left leg. (R9) has a cut on the top of her nose due to fall..." The facility's investigation regarding R9's incident of 3/21/2022, shows that V18 (CNA) assisted and placed R9 on a bed pan. During this task, R9 turned and rolled over to her right side, and slid off to the floor with bed bolster on. On 3/28/2022 at 3:30 P.M., V18 (CNA) was interviewed. V18 said on 3/21/2022 around 10:50 A.M., R9 had asked for a bed pan. V18 said at that time R9 was lying in bed in a supine position. V18 also said that R9 was positioned in the middle of the air loss mattress. V18 stated she grabbed a bed pan and " I pushed her buttocks for (R9) to turn to her right side, which was opposite of my side, I was on her left side. While I pushed her to turn to her right side, at the same time I placed the bed pan under her buttocks." V18 added R9 was holding on to the upper half siderail but got weak and was not able to hold on. V18 also said R9's was not able to actively	S9999		

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S9999	Continued From page 5	S9999		

participate and needed staff assistance to move her legs because of pain that R9 was having. V18 also said that "when I pushed (R9) to turn, she rolled too far over and slid off from the bed and ended up on the floor with her face down." V18 also added R9 requires 2-persons' physical assistance for turning and repositioning, transfers and toilet needs including providing a bed pan. V18 also said she did not asked help from another staff because the other CNA took a resident to the dialysis unit. V18 also said that "it's always been 2-person assistance when providing (R9's) toilet needs and placing the bed pan because (R9) has severe pain to her left knee, and she is dead weight. We must assist her to turn because she can only hang on to the half siderail but is not able to turn her lower extremities due to pain." V18 further said "(R9's) mattress and bed frame was small for (R9's) size, the width was too small and there was no space when R9 was turned to her sides, placing (R9) at the edge of the air mattress/bed frame. After the fall incident, (R9's) bed frame and air mattress were changed to a large size. I am small (physical stature), and I do not have to raise her bed when she fell, otherwise I don't know what would have happened. The air loss mattress also has no grip, so with no space and (R9) at the edge, she just slides off from the bed."

On 3/28/2022 at 1:31 P.M., V22 (Registered Nurse) said that on 3/21/2022 around 11:00 A.M., R9 had "rolled too far while being turned to the right side while she was in bed and ended on the floor."

The dietary assessment dated 2/16/2022 shows that R9 weighs 216.6 pounds and with a height of 65 inches.

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S9999	Continued From page 6 The care plan initiated on 2/16/2022 shows that R9 has an ADL self-care performance deficit related to impaired balance, and limited mobility. The interventions included in part as follows: "Toilet use: The resident requires total assistance by (2) staff for toileting including bed pan use. Transfer: The resident requires total assistance by (2) staff to move between surfaces." Further review of the care plan shows that R9 is "is at risk for falls related to deconditioning, gait/balance problems, hypotension and history of fall. The interventions showed " Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c.; Fall: 03/21/2022, Dycem (anti-slip pad) placed in bed, low bed, bolster to remind resident to always call for assistance. The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach." On 3/28/2022 at 1:20 P.M., V21 (Physiatrist) stated that she has been seeing R9 multiple times. V21 said that R9 was severely deconditioned and is very weak. V21 added that she had addressed R9's chronic left leg pain that is currently exacerbating. V21 further said that it is for the nursing and therapist to determine what was sufficient number of staff needed to assist R9. V21 added " I am there to consult." However, R9's EMR shows no documentation that there was integration of care based on R9's severe deconditioning, weakness and how ADL should be performed with R9's safety in place.	S9999		

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S9999	Continued From page 7	S9999		

On 3/28/2022 at 4:30 P.M., V2 (Director of Nursing) said the width of R9's bed when she fell on 3/21/2022 was 36 inches. V2 added after the fall, the bed frame and air loss mattress were changed to a large size with width dimension of 42 inches to accommodate R9's size.

The facility did not have any documentation to show that individualized interventions were put in place to prevent further falls for R9. There was no integration of care between the nursing assistants/nurses/therapist and physiatrist to determine individualized interventions and prevent fall and promote safety. The width dimension of the bed was not considered knowing it was not large enough to accommodate R9, the air loss mattress with no traction/grip control was not addressed as this would make a resident prone to sliding off the bed, and the exacerbated pain of the left leg that made R9 not actively participate in ADLs.

On 3/28/2022 at 10:30 A.M., R9 was observed lying in bed in a supine position. R9 said that she does not remember if she was holding unto the half siderail when she fell a week ago (3/21/2022). R9 said that V18 "pushed my behind, put the bed pan and I was rolled too far, slid off from the bed, ended to the floor and hit my face. I have a broken nose now from the fall. I have too much pain (was crying) in my knees especially my left knee and I cannot turn to my sides by myself." V18 and V19 (CNA) transferred R9 to the wheelchair using the mechanical total transfer lift device. This device is use for residents who cannot bear weight on their own. It was observed that when R9 was turned to her right side by V19, R9 was not pulled towards V19 (left side) prior to R9 being turned to the right

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S9999	Continued From page 8 side. This provided a tight space and placed R9 at the edge of the bed. On 3/30/2022 at 5:00 P.M., V2 said that the facility has no policy and procedure for safe turning and repositioning while a resident was in bed. V2 added that his expectation was for the staff to use a draw sheet and place a pillow wedge on the resident's back as a support and for the resident to be maintained in the middle of the bed. This procedure of turning does not address a safety issue of a resident being turned to the opposite side from the staff that was assisting. (B)	S9999		