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 04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2372597/IL158101	S 000		
S9999	Final Observations Statement of Licensure Violation 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 assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 ensure a resident was transferred by two facility staff members as shown on the resident's ADL (Activity of Daily Living) care plan. This failure resulted in R2 sustaining a head laceration following a fall due to an improper transfer. This applies to 1 of 3 residents (R2) reviewed for falls in the sample of 4. The findings include: On March 30, 2023, at 3:45 PM, R2 was sitting in her wheelchair in her room. R2 had two staples on the back of her head. R2 said, "A few days ago, I fell backwards in the shower and hit my head. There was only one CNA (Certified Nursing Assistant) with me when the shower was over. I was grabbing onto the bar, and I couldn't hold myself up anymore. The CNA was with me for most of the shower, but she had me stand up holding onto the bar in the shower while she got my wheelchair. I couldn't hold onto the bar anymore and I fell backwards." R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on April 1, 2022, with multiple diagnoses including chronic obstructive pulmonary disease, Alzheimer's disease, heart failure, osteoporosis, and anxiety. R2's MDS (Minimum Data Set) dated January 27, 2023, showed R2 was cognitively intact and required extensive assistance of two facility staff	S9999		

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S9999	Continued From page 2 for transfers. The MDS continued to show R2 required two facility staff physical assistance with bathing. R2's ADL (Activity of Daily Living) care plan dated April 7, 2022, showed "Resident requires assistance with bed mobility, transfers, locomotion in unit, locomotion off unit, ambulation, dressing, personal hygiene, eating, and bathing." The care plan continued to show multiple interventions dated April 7, 2022, including, "Provide two person assist with transfer." On April 3, 2023, at 10:31 AM, V6 (CNA) said, "I gave [R2] a shower on March 28, 2023. I put all of clothes on and helped her stand up using the shower bar. I went a couple steps away to get her wheelchair, but she let go of the shower bar and fell. She fell onto her butt and then hit her head on the wall. I transferred [R2] by myself. [R2] is supposed to be a two person assist for transfers." On March 30, 2023, at 3:25 PM, V8 (Nurse Practitioner) said, "[R2] fell in the shower and suffered a head laceration and a forearm skin tear. [R2] is on blood thinners so I wanted her to get a head CT (Computerized Tomography). She went to the hospital and got two staples for the head laceration. My expectation is staff follow a resident's transfer status. The improper transfer of [R2] is what could have led to her falling." On March 30, 2023, at 12:43 PM, V2 (Director of Nursing/DON) said V6 (CNA) performed an improper transfer of R2. V2 continued to say R2 required the assistance of two facility staff members to transfer. V2 said on the day of R2's fall, V6 transferred R2 by herself and did not have anybody else with her during the transfer.	S9999		

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S9999	Continued From page 3 A progress note dated March 28, 2023, at 11:57 AM, by V13 (Registered Nurse/RN) showed, "Assessment Findings: back of the head, occipital site bleeding, right forearm skin tears. Describe Incident in Detail: CNA stated that she was trying to transfer the patient after shower to the wheelchair, and patient lost balance and slid down to the floor. Send patient out to the emergency room." (B)	S9999		