Illinois Department of Public Health

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 01/09/2023

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

(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 Facility Reported Incident of 1/3/23/ IL155109 - 300.1210b)6) General Requirements for Nursing and Personal Care cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)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. 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. This requirement was NOT met as evidenced by: Based on observation, interview and review record, the facility failed to follow comprehensive assessments and resident care plan interventions for residents that needed supervision while	S9999	Attachment A Statement of Licensure Violations	

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

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eating. This failure resulted in residents (R1, R2) spilling hot soup on themselves and each obtaining burn injuries.

This applies to 2 of 3 residents (R1, R2) reviewed for supervision while eating in a sample of 3.

Findings include:

1. R1's face sheet documents that she is an 88-year Caucasian female who was admitted to the 3rd floor which is the licensure (private pay) skilled unit of the facility on 7/6/22.

R1 face sheet documents the following diagnoses: Alzheimer's disease, need for assistance with personal care, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, generalized anxiety disorder, gastro esophageal reflux disease without esophagitis, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.

R1's MDS (Minimum Data Set) dated 10/11/22 documents a BIMS (Brief Interview for Mental Status) score of 1, which means she is severely cognitively impaired. For eating, R1's score is 3/2, which means she needs extensive assistance with one person physical assist.

R1's care plans document that R1 is at risk for complications related to a history of CVA (Cerebrovascular Accident). Observe during meals for sign and symptoms of aspiration or choking. Notify medical doctor and document. R1 has an ADL self-care performance deficit related to spinal stenosis, dementia,

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arthritis/osteoarthritis. Eating: R1 requires extensive assistance by one staff to eat. R1 has cognitive impairments related to a diagnosis of dementia and exhibits behaviors. R1 is at risk for complications related to a history of CVA. Observe during meals for signs and symptoms of aspiration or choking. Notify medical doctor and document. R1 has impaired cognitive or impaired thought processes related to dementia. Cue, reorient, and supervise as needed.

On 1/7/23 at 9:40 AM, surveyor went R1's room. R1 was sleeping. Surveyor excused himself and called out R1's name. R1 woke up and smiled at surveyor. Surveyor asked R1 if she remembered burning herself. R1 was very confused and was unable to describe what happened on 1/3/23 regarding her dropping her bowl of soup and burn.

On 1/7/23 at 9:50 AM, surveyor went back to R1's room with V5 (RN-Registered Nurse). V5 showed surveyor R1's injuries. On R1's left forearm, she had a small blister with fluid and on her left thigh, there was a small spot of redness.

On 1/7/23 at 9:55 AM, V5 stated the following: "(R1) needs feeding assistance. She has dementia. Someone has to be with her and feed her. But if it's like a sandwich, then she can feed herself. It just depends on her really. Some days she can and some days she cannot feed herself, but she needs supervision. I was (R1's) nurse that day on 1/3/23 when she had the incident. (V4-CNA-Certified Nursing Assistant) was her CNA that day. What I heard was that (V4) wheeled (R1) into the dining room and put her at the table. While (V4) went to go get another resident from his/her room, a dietary server gave (R1) a bowl of soup. The CNA's were not in the

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S9999	Continued From page 3 dining room. They were transporting residents from their rooms to the dining room. Yes, someone should be monitoring the residents if they are eating in the dining room. It's important because residents could choke or in this case burn themselves. (R1) somehow dropped soup on her. (V3-CNA) heard (R1) yelling when she was in the hallway and ran to the dining room. (V3) then called me and I ran to the dining room. (R1) spilled soup on her left arm and thigh. There was redness on her thigh and redness and blister on her left arm. The blisters did not open. I put ice on both areas. I called the nurse practitioner and notified the family. The CNA's, not the dietary servers are supposed to deliver the soup to residents that are feeders or that need supervision. After the incident, (V2-DON/Director of Nursing) came and told us that kitchen staff should not be delivering food to confused residents. It should be a CNA." On 1/7/23 at 10:17 AM, V3 (CNA) stated, "On 1/3/23, I was working on the 3rd floor. I usually work on the 4th floor. (V4) was the CNA assigned to (R1). That day, I helped (V4) put (R1) in her wheelchair using the mechanical lift. Then (V4) took her to the dining room. As I was walking to the garbage chute to throw a bag of garbage, I heard (R1) yelling. I immediately ran to the dining room. I saw the bowl of soup in front of her and liquid dropped on the edge of her table. It was also on her leg and arm. I immediately called (V5-RN). (V5) and (V4) came and took (R1) back to her room. It was V10 (Dietary Aide) who passed out the soup to (R1). I overheard (V4) and (V5) talking. (V4) had told (V5) that she specifically told the dietary servers not to serve food to the feeders. (V4) and I were in and out of the dayroom. I didn't see the other two CNA's for the other hallways in the dining room because	S9999		

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their residents sit and eat in the other half of the dining room for lunch. When (R1) burned herself, there were no CNA's in the dining room. There might have been servers, but I can't remember. That's just common sense. A staff member has to be in the dining room regard less if the residents are doing any activities or eating. Especially with eating, because they could choke."

On 1/7/23 at 10:40 AM, V4 (CNA) stated, "Yes, I was (R1's) CNA on 1/3/23. I told the dietary servers if they can serve the residents that are feeders until the CNA's sit next to them because they spill and/or drop food. I did bring (R1) to the dining room and then I left to bring other residents into the dining room. V10 (Dietary Aide) delivered soup to (R1) without any staff sitting next to her. No one saw (R1) grabbing the soup. (R1) started screaming and (V3) heard the yelling. (V3) went to the dining room to where (R1) was sitting. (V3) called the nurse (V5) to come in. I heard the yelling then, so I came into the dining room. (V5) and I wheeled (R1) back to her room. We changed her shirt and (V5) applied ice. I'm not sure if there was another CNA in the dining room. V2 (DON) called me and told me that next time we are to ask the servers for the soup, serve the residents, and feed them. Prior to (V2) telling me this, I have told the servers to hold off serving food to feeders because a CNA has to sit next to them and supervise and/or feed them. (R1's) mood fluctuates. Mainly for breakfast, (R1) is total assistance when it comes to feeding. For lunch, it fluctuates, sometimes she can eat on her own and sometimes she needs help. For dinner, (R1) is wide awake and usually can feed herself. I know (V2) was going to get special cups for the feeders and they were working on getting a therapist to reassess (R1).

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On 1/7/23 at 10:48 AM, surveyor asked V10 (Dietary Server) if he served soup to R1 on 1/3/23. V10 said "Yes!" But then he said he doesn't speak English.

On 1/7/23 at 10:53 AM, V2 (DON) stated, "Yes, I was working the day that (R1) had her injury. My Assistant Director of Nursing notified me. Normally, the CNA bring residents to the dining room. The dietary servers serve food such as coffee and soup first. V10 (Dietary Aide) served (R1) soup without the CNA present. He should have waited for the CNA. We wouldn't want (R1) to be left alone with hot boiling soup when she has dementia. Sometimes, (R1) needs supervision. She has behaviors and get agitated. So, she needs encouragement. A CNA should be in the dining room monitoring because accidents like choking can happen."

On 1/7/23 at 11:00 AM, telephone interview was done with V13 (Nurse Practitioner). V13 works with V12 (Medical Doctor). Both R1 and R2 are patients/residents of V12. Surveyor asked V13 if servers are supposed to pass trays to residents who are feeders when CNA's are not present. V13 stated, "No, servers need to wait for the CNA to be sitting next to the resident because they need supervision. If the CNA's are not present, then the resident could play with the food and maybe drop it. In the case of (R1), she dropped the hot soup and it caused a burn/blister. Also, these residents need to be monitored, because what if the resident chokes and/or aspirates."

On 1/7/23 at 11:15 AM, V11 (CNA) stated, "I'm working today on the 3rd floor. I'm not (R1's) CNA today. I work PRN (As Needed). When residents are eating in the dining room, a CNA is

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S9999	Continued From page 6 assigned to monitor and supervise the dining room. The servers should put food in front of the residents when the CNA is in the dining room." On 1/7/23 at 10:53 AM, surveyor asked V2 (Director of Nursing) if R1 had any prior incidents of dropping food on herself and causing burns or other type of injury. V2 stated "Yes." On 1/7/23 at 1:30 PM, V2 submitted a previous incident report for R1. R1's incident report dated 10/12/22 documents the following: At around 12:10pm, (R1) was eating soup for lunch in a supervised dining room when she accidentally spilled the soup on herself. CNA (Certified Nursing Assistant) noticed as (R1) yelled and called writer to the scene. Writer observed redness to the left arm near the elbow and left side abdomen under the breast. Cold compress was applied immediately. Vitamin A & D ointment applied after cold compress. ADON (Assistant Director of Nursing), wound nurse, and medical doctor made aware. Vital signs within normal limit. Tylenol given for pain. Left voicemail for Power of Attorney (son) to give call back. Will continue to monitor. Conclusion: Description of what happened: At 12pm, (V6-CNA) stated she was bring another resident into the dining room after he completed his restorative exercises and wheeling him to the table to get him settled. (V6) heard (R1) scream out and (V6) looked over and saw a tipped over bowl of soup spilled. (R1's) shirt and sleeve were wet. (V6) stated she pulled (R1's) wet long sleeve shirt back on arm and slightly lifted wet shirt and placed napkins between shirt and skin as wheeling (R1) out of the dining room towards her room. When exiting the dining room, (V6) reported the incident to (V7-RN-Registered	S9999		

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S9999	Continued From page 7 Nurse). (V7) and (V6) went to (R1's) room and body check was initiated. Upon initial observation, (V7) noted redness on (R1)'s left outer arm near elbow and left side of abdomen/breast. Applied cold compress to areas of redness. (V7) called wound care nurse and (R1's) burn areas were assessed. The left forearm had the start of a formation of a blister 1.9 cm (centimeters) x 1.3 cm and surrounding redness in evolution. After multiple cold compresses, the left breast and left abdomen have pale pink intact skin and no further redness noted. (R1) did not remember the incident. (V4-CNA), (R1's) assigned CNA stated she took (R1) to the dining room for lunch and set her at the table. (V4) then went to get another resident to bring down to lunch and heard (R1) yelling. (V4) saw (V6) bringing (R1) down the hall. (V7) was called and assisted to put cold cloths and then ice on arm and abdomen. (V8-Dietary Server) reported that he did not witness the incident. He was serving in the dining room and was preparing other residents' meals to serve them and heard (V4) that (R1) spilled her soup. (V9--Dietician) was not present when incident happened. (V9) was interviewed to check for the soup temperature. Per (V9), soups are being checked for temperature and at the time of the incident, the was soup was 165 degrees F (Fahrenheit). According to (V9), this is an acceptable temperature for serving." R1's current facility reported incident dated 1/3/2023 documents the following: "(R1) noted to be sitting in the dining room at a table with other residents at approximately 11:30am. No food had been served yet. At approximately 11:45m, notified by CNA that (R1) had spilled her soup. (R1) noted to have soup on her left sleeve and front of her shirt down to her left thigh. Bowl	S9999		

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S9999	Continued From page 8 sitting on the table. (R1) skin assessed and redness noted to left forearm and left thigh. Soiled clothing removed and ice applied to areas. Fluid filled blister with surrounding redness noted to left inner forearm measuring 1.6 cm x 3.5 cm and left outer forearm measuring 2.7 cm x 2.9 cm. (R1) denies pain. (R1's) POA (Son) updated on situation. Nurse practitioner notified. V2 (DON-Director of Nursing) notified. Will continue to monitor. (R1) did not remember how incident happened. (R1) had no complaint of pain with touch or during dressing application to her forearm. (V3--CNA) stated she was in the hallway helping another resident to get ready for lunch. (V3) heard (R1) yell. (V3) immediately checked and observed (R1) wiping off some soup from her left arm. (V3) stated she did not witness the incident. (V3) stated that another CNA also came and nurse responded to (R1) yelling. (V4-CNA) stated she took (R1) to the dining room for lunch and set her at the table. (V4) then went to get another resident to bring down to lunch and heard (R1) yelling. (V4) responded immediately and saw another CNA was there checking (R1) that also responded to (R1) yell. (V4) noted (R1) had some soup on her left forearm. (V5-RN) stated she heard (R1) yelling in the dining room. (V5) said she immediately responded and when she got to the dining room, she saw (V3) assisting (R1) and noted left arm with redness and blister from the soup. (V5) immediately applied for an ice pack to the area and conducted an initial interview with residents. Residents were unable to tell the details of the incident and (R1) denied any pain or discomfort. Based on investigation and interviews, (R1)'s need for assistance with eating varies from set up to dependence. Dietary server gave (R1) soup. Soup is being temped at 165 degrees F with appropriate serving temperature. (R1) might	S9999		

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S9999	Continued From page 9 have attempted to eat soup and spilled on her arm. Intervention: Initiated treatment per doctor's order. Occupational Therapist to evaluate and treat for possible use of adaptive equipment. CNA will be the one serving soup instead of dietary server." R1's Occupational Therapy Plan of Care dated 10/28/22 documents the following: "Reason for Referral: (R1) requires 24 hour supervision/assistance with all aspects of care. On 10/19/22, (R1) was referred to OT (Occupational Therapy) for assessment of feeding skills for possible AE recommendations status post dropping hot beverage and scalding herself. At today's assessment, (R1) demonstrated significant neurocognitive impairments with delayed processing of information to follow 1 step directions and prior new learning, WFL AROM (Active Range of Motion) with weakness in BUE's (Bilateral Upper Extremities), poor activity tolerance and requires total assistance for all aspects of self care like self feeding. (R1) is being fed but demonstrates ability to self feed. AE maybe recommended. Skilled services are reasonable and necessary to further assess self feeding skills and recommend appropriate AE to promote independence and prevent injuries." Occupational Therapy Plan of Care dated 10/29/22 documents: "(R1) is unable to feed self-utilizing regular utensils, requiring total assist (100% assist) with initiation cue and verbal, tactile and visual instruction/cues. Goal: (R1) will effectively utilize spill proof cup and other AE as recommended to safely feed 25% of meal increasing to moderate assist (50% assist) and other AE as recommended to feed with initiation cue and verbal, tactile and visual	S9999		

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S9999	Continued From page 10 instruction/cues." Occupational Therapist Progress and Discharge Summary dated 11/12/22 documents: "(R1) has been provided with spill proof cup and utilizes with cues. Training has been provided to caregivers and (R1) with spill proof cup with good carryover. (R1) requires 24-hour supervision and total assistance at this time due to continued deficits. (R1) has made progress with self feeding and has reached her HLOF. With carryover with AE and allowing her to perform self feeding to her HLOF, (R1) has good potential to maintain her gains. (R1) will remain on the long-term care unit with supervision/assistance required for all aspects of care." On 1/7/23 at 1:45pm, surveyor asked V2 (DON) for the occupational therapist evaluation and assessment for R1's recent incident on 1/3/23 regarding dropping soup on her body and resulting in a burn. V2 stated that the fall happened 4 days ago and the occupational therapist hasn't seen (R1) yet. 2. R2's face sheet documents an admission date of 5/12/2022 to the 3rd floor which is the skilled unit. R2 is in a licensed bed. R2's face sheet indicates that he has the follow diagnoses: muscle weakness, need for assistance with personal care, unspecified abnormalities of gait and mobility, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and anxiety disorder. R2's MDS (Minimum Data Set) dated 10/24/22 documents a BIMS score of 10 which means R2	S9999		

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is moderately cognitively intact. R2's eating score is 1/1, which means he needs supervision and set up help.

R2's care plan documents that he has an ADL self-care performance deficit related to impaired balance and limited mobility. Eating: R2 is set up assist for eating.

R2's incident report dated 12/28/22 documents the following: "Writer went to check on (R2) at 5:55pm and (R2) noted to have spilled soup on his abdomen down to his left thigh. (R2) was attempted to clean soup off him. Bowl noted on the floor next to his bed. (R2) denied any pain. Abdomen noted to be red. Area cleaned and ice applied. CNA assisted to remove dirty clothes. Left hip noted to have blister. Ice applied to area. Abdomen noted to have two fluid filled blisters. (R2's) POA (Power of Attorney) notified of the situation. (R2) continues to deny pain. Will continue to monitor. Conclusion: At 5:55pm, (V5--RN) was doing rounds and checked on (R2) and noted (R2) spilled his soup on his abdomen and (R2) was attempting to clean the soup off him. After completing the initial assessment, (V5) notified (V12-Medical Doctor) with order received for treatment of Silver Sulfadiazine."

Occupational Therapy Plan of Care dated 1/3/23 documents the following: "This is an 81-year-old male resident of long term care unit with past medical history of dementia who was referred to Occupational Therapy for feeding recommendations following a spillage of hot liquid onto himself during a meal. Initial assessment revealed a known confused gentleman with decreased AROM (Active Range of Motion) with increased weakness in BUE's (Bilateral Upper Extremity), poor activity tolerance, decreased

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 01/09/2023

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

(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
S9999	Continued From page 12	S9999		

sitting balance/tolerance, dependent sit to stand, standing balance/tolerance, transfers and home mobility who requires total assistance with all aspects of self-care. (R2) could feed himself with set-up, but he has suffered a decline which increases his jeopardy of lack of nutrition and decreased safety with increased assistance required. His past participation has been inconsistent, but he expresses want to be able to self feed. Supervision or touching assistance. Help provides verbal cues or touching/steadying assistance as (R2) completes activity. (R2) is able to feed self utilizing spill proof cup requiring minimum assist (25% assist) with verbal, tactile, and visual instructions/cues."

On 1/7/23 at 11:30 AM, V5 (RN) stated, "I'm not sure which server served (R2) soup. When I was doing rounds, I saw (R2) in his room with his bowl on the floor. (R2) could not recall what happened. (R2) has dementia. (R2) had spilled soup on his abdomen and on his thigh. He developed blisters which opened up. I called his doctor. I applied ice, ointment, and dressing."

On 1/7/23 at 11:34 AM, surveyor and V5 went to R2's room. V5 showed surveyor R2's dressing on his abdomen and left thigh. Surveyor asked R2 what happened the day he burned himself. V5 was very confused and stated to surveyor that he doesn't remember.

On 1/7/23 at 12:07 PM, V14 (R2's daughter) was in the facility visiting R2. V14 stated that R2 burned himself in his room. V14 stated, "(R2) can eat by himself but he does have dementia. He can benefit from being monitored. (V2) stated that (R2) would be served in hard containers, which would help him from dropping the soup. I was here last Sunday on 12/31 and he was

Illinois Department of Public Health

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	IL6003032	A. BUILDING: ______ B. WING ______	C 01/09/2023

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OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

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S9999	Continued From page 13 served soup in a foam bowl. That's not safe. He could pinch it and break it and then it could fall on him. V14 showed surveyor a picture of the foam bowl on her cell phone. On 1/7/23 at 1:50pm, V2 (Director of Nursing) stated that R2 burned himself in his room by dropping a bowl of soup on him. V2 confirmed that if the MDS documents that R2 needs supervision and if he is confused, he should be eating in the dining room where he can be supervised. V2 also stated that R2's soup should be served in a hard container to prevent spills and dropping. Facility's policy Assistance with Meals (3/1/22) indicates all residents will be encouraged to eat in the dining room. Community team members will serve resident meal and will help residents who require assistance with eating. Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. (B)	S9999		