STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002612	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUPAGE CARE CENTER	400 N COUNTY FARM RD WHEATON, IL 60187

(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 2474516/IL174126	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

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S9999	Continued From page 1	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 that each resident receives adequate supervision and assistance to prevent accidents.

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These Requirements were not met evidenced by:

Based on record review and interview, the facility failed to ensure two staff assisted in transferring a resident safely while using a mechanical lift. This failure resulted in R2 falling from the mechanical lift to the floor, sustaining a right tibia fracture and an occipital contusion and transfer to the emergency department. This Applies to 1 of 5 residents (R2) reviewed for falls and accidents in a sample of 9.

A care plan initiated on 10/30/2023 showed that R2 needs two staff members to assist with ADLs (Activities of Daily Living), including transfers from bed to wheelchair and vice versa. The MDS (Minimum Data Set), dated 11/22/2023, showed that R2 is cognitively intact and dependent on ADLs, requiring two or more staff members to complete activities such as transfers, dressing, personal hygiene, and bathing.

A review of R2's face sheet and physician's progress notes dated 01/24/2024 showed R2 was an 83-year-old admitted to the facility initially on 05/01/2023 with diagnoses including muscular dystrophy, osteoarthritis, history of falls, disease of the spinal cord, history of multiple traumatic fractures, lack of coordination, vitamin D deficiency, progressive weakness, wheelchair-bound, and chronic obstructive pulmonary disease.

On 06/13/2024 at 01:04 PM, R2 was in bed, alert, oriented to person, place, and time, and was interviewable. R2 said, V12 (Certified Nursing Assistant) put him in a mechanical lift by herself, and the sling was smaller to him. R2 said when

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she lifted him from the bed, his groin hurt, and he told V12 to take the sling off. R2 said V12 played around with the sling and took the mechanical lift near the door where his power wheelchair was, and he fell from the mechanical lift and broke his right leg and blood was coming from the back of his head. R2 said V12 ran outside the room and told other staff that she had dropped him and staff had come to assist him.

Nursing progress notes dated 01/21/2024 showed that at 8:40 AM, R2 had a witnessed fall during transfer, causing injury to the head (occipital region) and right knee pain. The nursing progress notes further showed that R2 was sent to the emergency department for evaluation.

R2's hospital emergency department Physician history and physical dated 01/21/2024 showed 83-year-old R2 presented to the hospital on 1/21/2024 with a complaint of a fall from the mechanical lift with an injury to the right leg below the knee with pain and side of the head lacerations.

X-ray of the right tibia fibula lateral view on the same day showed medial tibial plateau fracture and treated with knee immobilizer 24/7 for three weeks and Neosporin antibiotic cream dressing for scalp after cleaning.

On 06/13/2024 at 2:00 PM, V2 (Director of Nursing) said R2 uses a mechanical lift with two staff members assisting, and he fell from the mechanical lift while V12 (Certified Nursing Assistant-Agency) was transferring R2 from bed to his wheelchair. V2 said V12 should have waited for another staff member to help R2 transfer. V2 said the facility is not using V12 anymore, investigated, educated staff on the

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S9999	Continued From page 4 mechanical lift transfer, and reported to IDPH. On 06/13/2024 at 2:10 PM, V6 (Certified Nursing Assistant) said he is a regular staff member in that unit and that they should always use two or more staff to transfer residents from the mechanical lift. V6 said R2 is a dependent resident for ADLs, and V12 should have called for help to transfer R2 using the mechanical lift. A facility's policy titled "Transfers-EZ Lift/EZ Stand" stated, in part, that each resident will be assessed to determine the mode of transfer and the level of staff involved. (B)	S9999		