STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING: _____ B. WING _____	C 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

(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 FRI of 6/26/2024/IL174909	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 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. 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. These Requirements were NOT MET as evidenced by:	S9999		

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S9999	Continued From page 1	S9999		

Based on record review and interview, the facility failed to ensure staff used the wheelchair's footrests during transportation. This failure resulted in R4 falling from the wheelchair to the floor sustaining a forehead laceration and transfer to the emergency department.

This Applies to 1 of 3 residents (R4) reviewed for falls and accidents in a sample of 10.

A care plan revised on 04/24/2024 showed that R4 has risk factors that require monitoring and intervention to reduce the potential for self-injury. The updated care plan on 06/19/2024 instructed staff to instruct and help R4 use footrests when he is in his wheelchair. The MDS (Minimum Data Set), dated 05/27/2024, showed that R4 was cognitively severely impaired and dependent and required substantial assistance for ADLs, requiring two or more staff members to complete activities such as transfers, dressing, personal hygiene, bathing and ambulation or walking required moderate to partial assistance, and activity was not attempted.

A review of R4's face sheet showed R4 was an 81-year-old admitted to the facility initially on 11/25/2023 with diagnoses including cerebral infarction, vascular dementia with behavioral problem psychosis, depression, and cardiac diseases. On 06/25/2024 at 11:30 AM, R4 was in a specialized chair and awake and minimally interviewable. R4 said while V11(Certified Nursing Assistant) was wheeling him in a wheelchair, he stepped his feet on the floor.

Nursing progress notes and post-fall assessment dated 06/19/2023 at different times showed R1 was confused due to dementia, R4 had forehead laceration, new onset of pain observed,

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S9999	Continued From page 2	S9999		

complained of headache with a pain level of 6/10, and was sent to the hospital, and returned to the facility same day with two inches of stitches on the left side of the forehead and black and bluish discolorations under residents' eyes.

On 06/26/2024 at 11:49 AM, V11 (Certified Nursing Assistant) said he was wheeling R4 in his wheelchair to his room from the dining hall after breakfast, and R4 braked his wheelchair by putting his feet on the floor and fell out of the wheelchair and onto the floor. V11 said all residents should have footrest while wheeling, and he did not attach the footrest to the wheelchair at the time of R4's transfer to his room. V11 said from now on, he will ensure residents will have footrests while transferring and further said, "That is a big lesson for me."

On 06/25/2024 at 12:00 PM, V2 (Director of Nursing) said staff should ensure residents' feet are rested on the footrest during any transport in a wheelchair.

(B)