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 05/20/2024

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 Facility Reported Incident of 5/4/24/IL173076	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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. 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.	S9999		

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow their policy to ensure residents were safely transferred. This failure resulted in R1 sustaining a fall and being hospitalized with a subarachnoid hemorrhage/contusion of the right side of the brain. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.

The findings include:

1. On May 15, 2024 at approximately 2:15 PM, R1 was lying in bed in her room. R1 was unable to answer questions due to her cognitive status.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on January 4, 2023. The EMR continues to show R1 was transferred to the local hospital on May 4, 2024 following a fall and returned to the facility on May 5, 2024.

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R1 has multiple diagnoses including, anorexia, unsteadiness on feet, weakness, dementia, lack of coordination, muscle weakness, dysphagia, major depressive disorder, head laceration, hypertension, and glaucoma.

R1's MDS (Minimum Data Set) dated April 4, 2024 shows R1 has severe cognitive impairment, requires supervision with eating and oral hygiene, requires partial/moderate assistance with toilet transfers, tub/shower transfers, and self-propelling her wheelchair. R1 requires substantial/maximal assistance with toilet hygiene, personal hygiene, bed mobility, and transfers from a sit to stand position, and chair/bed to chair transfers. R1 is totally dependent on facility staff for showering/bathing and dressing. R1 is always incontinent of bowel and bladder.

On May 4, 2024 at 5:42 AM, V9 (LPN-Licensed Practical Nurse) documented, "[R1] observed lying flat on back on floor feet resting on sit-to-stand [mechanical lift]. Hematoma to back of head noted ice applied, no active bleeding noted, denied pain at this time. 911 called to assist [R1] off floor and transport to [ER-Emergency Room] for eval. MD (Medical Doctor), POA (Power of Attorney), Supervisor, and DON (Director of Nursing) notified."

The facility's final report to IDPH (Illinois Department of Public Health) dated May 6, 2024 shows: "98-year-old [R1] sustained a fall during a transfer using the [sit-to-stand mechanical lift]. She was transferred to the hospital for further evaluation and was found to have a subarachnoid hemorrhage/contusion right parietal and small hemorrhagic contusion left thalamus ..."

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The facility's fall investigation shows multiple facility staff members were interviewed. The fall investigation interviews include the following statements by V3 (CNA-Certified Nursing Assistant), V4 (CNA), and V9 (LPN):

V3's (CNA) witness statement dated May 4, 2024 shows: "I was transferring [R1] with the [sit-to-stand mechanical lift]. She was buckled in tight with her arms on the handlebars. As I was lifting her up, she started to slide out and I couldn't get her back in the chair fast enough to catch her from falling. I don't know if she became weak and her knees buckled. It happened pretty quickly."

V4's (CNA) witness statement dated May 4, 2024 shows: "I was in [R1's room] with another staff member (V3-CNA). We were giving care to both residents. I went over to [R1's] side to assist with the transfer in the [sit-to-stand mechanical lift]. The staff member had the resident in position for the transfer from bed to wheelchair. I stepped out of the room because I heard yelling down the hall. As I was walking towards the yelling, another staff member was coming out to ask for assistance. After helping in the other room, I returned to [R1's] room. When I got there, the resident was already on the floor with the safety belt still on."

V9's (LPN) witness statement dated May 7, 2024 shows: "I was down the hall when [V3] (CNA) came out of [R1's] room. I asked her if everything was alright, but she said no, [R1] is on the floor, she slipped out of the lift. When I entered the room, [R1] was lying on the floor in a supine position. I noted a bump to the back of her head. [R1] denied any pain and did not want to go to the hospital ..."

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On May 15, 2024 at 1:28 PM, V3 (CNA) said, "I had [R1] dressed up and ready to transfer to the bathroom. I had [V4] (CNA) with me and I buckled [R1] into the sit-to-stand mechanical lift. I was trying to take her to the bathroom, but someone called out for [V4] (CNA) to help another resident. She said she would be right back, and she left the room. I continued with the mechanical lift transfer by myself, and [R1] slipped out of the sling. I was heading towards the bathroom, and she slipped out of the sling. [R1] gave up from holding on, and her legs buckled, and she fell through the sling. She hit her head pretty hard on the floor. The nurse came in and she heard what happened. The transfer started with two people, but [V4] left the room before the transfer actually started. They specifically said we are always supposed to have two people for any transfer, including stand and pivot transfers. That has always been in place."

On May 15, 2024 at 10:56 AM, V2 (DON) said, "They started [R1's] transfer with two CNAs, but the one CNA left the room, and the other CNA transferred the resident alone, using the mechanical lift, and [R1] fell. They are supposed to have two CNAs in the room the entire time they use the sit-to-stand."

R1's CT of the head report from the local hospital, dated May 4, 2024 shows: "Impression: 1. Small volume subarachnoid hemorrhage/hemorrhagic contusion in the right parietal region. Small hemorrhagic contusion left thalamus/caudate tail ...."

R1's hospital records dated May 5, 2024 at 5:06 PM show: "Assessment/Plan: Trauma - major. Injury List: SAH (Subarachnoid

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Hemorrhage)/contusion right parietal (right side of brain), small hemorrhagic contusion left thalamus (center of brain)."

R1's hospital records show R1's subarachnoid hemorrhage was related to trauma. R1's hospital records do not show R1's subarachnoid hemorrhage was spontaneous in nature or caused by another chronic medical condition.

On May 16, 2024 at 10:38 AM, V7 (Physician) said, "The circumstances of [R1's] fall tell me that the subarachnoid hemorrhage was caused by the fall. Her muscle weakness and dementia maker her high risk for falls. I expect the facility to follow their policies when transferring residents."

The facility's undated policy entitled "Using a Mechanical Lifting Machine" shows: "Purpose: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. This policy does not supersede manufacturer's training or instructions. General guidelines: 1. At least two (2) nursing/therapy staff are recommended to safely move a resident with a mechanical lift. Refer to manufacturer's guidelines for specific guidance on requirements for sit-to-stand lifts versus full body sling lifts."

The sit-to-stand mechanical lift Operator's Instructions, "Rev. 09/29/2023" shows: "The [sit-to-stand mechanical lift] was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary ..."

(A)