STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145804	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Trace	250 Village Drive Downers Grove, IL 60516

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 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 2 of 3 residents (R1, R3) 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 [DATE]. 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 [DATE]. 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: [AGE] 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 . (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 . 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 Hemorrhage)/contusion right parietal (right side of brain), small hemorrhagic contusion left thalamus (center of brain). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 . 2. On May 15, 2024 at approximately 2:50 PM, R3 was sitting in her room. R3 was not able to be interviewed due to her cognitive status. The EMR shows R3 was admitted to the facility on [DATE]. R3 has multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease), weakness, dysphagia, dementia, UTI (Urinary Tract Infection), chronic respiratory failure, anxiety disorder, and history of falling. R3's MDS dated [DATE] shows R3 has severe cognitive impairment, requires setup assistance with eating and oral hygiene, partial/moderate assistance with toilet hygiene, dressing, and bed mobility, and substantial/maximal assistance with showering/bathing, personal hygiene, and transfers between surfaces. R3 is frequently incontinent of urine, and always incontinent of stool. R3's Fall Risk Assessments dated March 21, 2024 and May 10, 2024 show R3 is at risk for falling. R3's fall risk care plan, initiated on April 15, 2022 shows multiple interventions. An intervention initiated on July 15, 2022 and revised on May 4, 2024 shows: [R3] requires extensive gait belt assistance by (1) staff to move between surfaces. On May 10, 2024 at 5:18 PM, V14 (RN-Registered Nurse) documented, At around 8:00 AM, CNA summoned nurse and informed nurse that resident is on the floor. Observed resident sitting on the floor mat in front of her wheelchair. Per CNA, she assisted resident getting up from the bed to transfer to chair, but her knees buckled down, so she lowered her slowly to the floor. No injuries noted. Able to move upper and lower extremities . The facility's fall report dated May 10, 2024 at 8:11 AM shows: CNA summoned nurse and informed nurse that resident is on the floor. Observed resident sitting on the floor mat in front of her wheelchair. Per CNA, she assisted resident getting up from the bed to transfer to the chair, but her knees buckled down, so she lowered her slowly to the floor. No injuries noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On May 15, 2024 at 3:37 PM, V13 (CNA) said, I went to [R3's] room to get her ready for breakfast, and the nurse said we had to get her up to the chair after I changed her [incontinence brief]. I put my arm under her armpit and held her [incontinence brief]. I did not use a gait belt. She was unable to support herself on her own and started to fall, so I started guiding her down to the floor mat. I made sure she was okay, and I went and got the nurse, and we got her up. We put our arms under her arm pits and grabbed her [incontinence brief] and picked her up. We did not use a gait belt to get her up. The nurse did not correct us or say we were doing it wrong, or we should have used a gait belt. I mean, you would think she would have said something if we were doing it wrong, don't you? I asked them where the gait belts were, and they told me I was going to have to wait to find one. I have worked at the facility for two months now. They never trained me on the fact that I had to use a gait belt every time I transferred someone. They just told me the basics. I don't usually work in the skilled area of the facility. I usually work in assisted living and that is probably why I didn't get trained on gait belts. The facility called me after this happened and told me that we always have to use a gait belt. I did not see that [R3] needed a gait belt for transfers in the computer. R3's Kardex Report as of May 10, 2024 shows: Category Transferring: Transfer: The resident requires extensive x gait belt assistance by (1) staff to move between surfaces. On May 15, 2024 at 1:37 PM, V6 (Therapy Program Director) said, [R3] fell on [DATE]. We evaluated her in July 2023 and determined she was a one-person maximum assist with transfers. They should have used a gait belt on her and done a stand and pivot transfer. They should always use a gait belt when transferring residents. The facility's undated policy entitled Gait Belt Procedures shows: Policy: Patient care providers will use gait belts when ambulating or transferring patients who are unsafe to ambulate/transfer independently.