STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. Building B. Wing	05/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Residence	1400 Brookdale Road Naperville, IL 60563

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. Based on interview and record review, the facility failed to ensure a resident did not fall out of bed after being turned during incontinence care. This failure resulted in the resident slipping off the bed and experiencing bilateral distal femur fractures requiring bilateral femoral retrograde rodding. This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 3. Findings Include:Review of R1's care plan shows R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting her left side, osteoarthritis, and dementia with impaired thought processes. R1 was at increased risk for falls related to her weakness, hemiplegia, poor balance/coordination, and medications. R1 utilized a pressure-relieving mattress on her bed, had altered functional range of motion of her left side, required a mechanical lift and two staff for transfers, used 1/4 side rails to enable bed mobility, and prior to her fall required the maximal assistance of one staff but may need two staff at times for bed mobility. MDS (Minimum Data Set), dated 4/14/26, shows R1's cognitive status was intact and R1 required substantial and maximum assistance (more than half the effort provided by staff including lifting or holding trunk or limbs) to roll right and left in bed. On 5/15/26 at 9:49 AM, V4 (Certified Nursing Assistant/CNA) stated he was performing incontinence care and told R1 he was going to turn her to her left side. V4 stated R1 was lying on her back in the middle of her bed. Without moving R1 further to right in her bed, V4 turned R1 from the middle of her bed by pushing R1 away from V4. R1 held the left bed rail with her right hand and V4 turned his head back to retrieve wipes from her table which was behind V4. As V4's head was turned, R1 slid off the bed and landed the floor on her knees while still holding the rail. V4 stated R1 complained of pain in her knees throughout his shift. V4 stated he was provided education after the fall regarding gathering his supplies in front and close to him when performing incontinence care as well as turning a resident toward him instead of away from him. Witness statement written by V4, dated 4/29/26, shows V4 told R1 he would turn her to her left to clean her bottom and V4 reached for wipes on the table. The statement shows when V4 turned his head back for the wipes, R1 fell off the bed and he rushed to the other side to help her. V4 saw R1 on her knees and was holding the side rail of the bed and V4 called for help. The statement shows two nurses assessed R1 and the staff assisted R1 back to bed. Hospital physician note, dated 4/30/26, shows R1 apparently landed on her knees while getting in or out of bed. She does have a large bruise on the inside of her left knee. Hospital X-ray results of her left knee, dated 4/30/26, show R1 had an acute, complex fracture of the distal femoral metaphysis with displacement and apex anterior angulation at the fracture site. Hospital Xray results of R1's right knee, dated 4/30/26, show mildly comminuted fractures of the distal right femur with impaction and angulation with mild displacement of multiple fragments. Nurse Practitioner Progress notes, dated 5/11/26, shows, .Patient suffered a fall while staff was repositioning her in bed which resulted in bilateral distal femur fractures. Patient subsequently underwent bilateral distal femoral retrograde rodding on 5/5/26. Orthopedic surgery discussed goals of care and treatment options extensively with family members. Patient has now returned to facility for continued skilled nursing care and PT/OT (Physical and Occupational Therapy) rehabilitation services as tolerated. On 5/15/26 at 9:23 AM, V3 (Director of Nursing) stated V4 (CNA) turned R1 in bed and then turned around to the table to (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. Building B. Wing	05/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Residence	1400 Brookdale Road Naperville, IL 60563

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	grab wipes when R1's feet started to slide off the bed, her body followed, and R1 landed on the floor in a kneeling position on her knees. R1 was assessed by nurses and reported knee pain, was transferred back to bed by staff using a mechanical lift, and V3 assessed her knees approximately 30 minutes after the fall. V3 stated she saw no redness or swelling of R1's knees, R1 still reported pain in her left knee, and an X-ray was ordered. V3 stated the X-ray did not arrive until the next morning and R1 continued to report pain in her knees, so R1 was sent to the hospital where X-rays were performed, the fractures were identified, and surgery was performed. At 10:31 AM, V3 stated R1 should have had all of his supplies prepared and in front of him so he did not have to look away from R1. At 2:32 PM, V3 stated the facility recently implemented procedures to have all staff turn residents toward them when turning residents in bed. V3 stated she was not sure if there were specific instructions for turning residents on air mattresses. V3 stated R1 was utilizing an air mattress at the time she fell. Developmental Feedback Worksheet, dated 5/4/26, shows V4 was educated to ensure residents were turned toward him for safety while providing incontinence care to reduce the risk of falls or injury. Facility Education Document, undated, shows, During incontinence care always turn the resident towards you. Turning the resident toward you allows you to maintain control and balance, reducing the risk of falls or injury to both the resident and staff member. Air mattress manufacturers' information, undated and provided on 5/15/26 by the facility, shows the mattress dynamically adjusted pressure to the patient profile using air cells. On 5/15/26 at 9:55 AM, V5 (Agency Registered Nurse) stated V4 was changing R1's incontinence brief when V4 reached for wipes and R1's legs slid from the bed followed by her body. V5 stated R1 landed on her knees with her buttocks on her feet and when V5 arrived R1 was attempting to remove her feet from under her buttocks. R1 was verbalizing she was in pain/agony by saying Ow.ow! loudly while the staff used the mechanical lift to put R1 in bed. R1 was guarding her knees after the fall and staff assessed R1 for injuries. V5 stated she provided medication for pain and did not suspect injuries at that time. R1 was ordered an in-facility X-ray to assess for injuries and was sleeping when V5 finished her shift. Witness statement written by V5, dated 4/29/26, shows V5 entered the room and R1 was on the floor screaming in pain. V5 assessed R1 and R1 reported pain of 8 on a scale of 10 with 10 being the worst pain. The statement shows V5 assisted staff using a mechanical lift placing R1 back into bed. On 5/15/26 at 11:11 AM, V6 (CNA) stated when she arrived in R1's room after her fall, R1 was kneeling on the floor with her buttocks on her feet and R1 was screaming in pain when being moved. V6 stated V5 instructed the staff to place R1 in bed using a mechanical lift and once R1 was in bed she did not verbalize pain unless her legs were touched. V6 stated prior to the fall, R1's legs were never straight and were slightly bent. Witness statement written by V6, dated 4/29/26, shows V6 entered R1's room and saw R1 on her knees with her thighs touching her calves. On 5/15/26 at 1:45 PM with V8 (Nurse Practitioner), V7 (Physician) stated R1's fall from bed caused fractures and resulted in her surgeries to repair the fractures.Interdisciplinary Progress note, dated 5/1/26, shows, Resident experienced fall on 4/29/2026 during provision of incontinence care by staff. During care staff briefly turned away from resident, at which time slid out of bed onto floor while holding on to siderail. Resident was assessed by 2 nurses before being transferred back to bed via [mechanical] lift per policy. Resident remained in the facility for continued monitoring. POA (Power of Attorney) and Medical NP (Nurse Practitioner) informed. Resident was subsequently transferred to [hospital] on 4/30/26 for further evaluation after compliant of pain even after medication was administered. POA and Medical NP notified. [Hospital] update injury: Closed fracture of distal end of right and left femur, unspecified fracture morphology, initial encounter. At time of incident, resident had underlying medical conditions including pneumonia and anemia, which likely contributed to the increased weakness and fatigue. These factors significantly increased the resident's risk for instability during care.