STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006738	A. BUILDING: _____ B. WING _____	C 05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREST	2944 GREENWOOD ACRES DRIVE DEKALB, IL 60115

(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
S9999	Final Observations	S9999		

Statement of Licensure Violation:

300.690b)
300.690c)
300.1210b)
300.1210d)6)

Section 300.690 Incidents and Accidents
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident
This REQUIREMENT was not met as evidenced by:
Based on interview and record review the facility failed to notify the Illinois Department of Public Health within 24 hours of a resident fall resulting in a head laceration.
This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.
The findings include:
R1's Problem List of February 27, 2016 showed diagnoses of Alzheimer dementia and cerebrovascular accident, was nonverbal and required full assistance with ADLs (activities of daily living). R1's Fall Risk Assessment of January 21, 2016 showed a high risk level and a fall reduction approach "bed in lowest position when resident in bed". R1's Resident Care Guide of January 21, 2016 showed difficulty with short and term memory, unable to follow directions, and staff assistance for hygiene/dressing. The Care Guide also showed a transfer need of "mechanical lift with two person assist" and "keep bed in the lowest position".

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

On May 6, 2016 at 1:15 PM, E2 Certified Nurse Aide (CNA) stated she was rolling R1 from side to side while dressing her in bed on April 13, 2016. E2 said she took care of R1 "a lot, knew her needs pretty well, and knew she was a fall risk". E2 said she was the only staff present in R1's room while assisting her on April 13, 2016. E2 stated, "She (R1) was flaying her legs a lot while I was dressing her and 'like kicking or jerking' which was typical for her." E2 stated she stepped away from R1's bed, "I turned my back to get the Hoyer (mechanical lift) out of the bathroom when I heard her fall out of bed and onto the floor. Her head was bleeding." E2 stated, "She (R1) was lying down in the bed when I walked away from her, but usually someone is with her, by her side when we (CNAs) get the lift out of the bathroom." R1's Resident Care Guide Addendum dated April 13, 2016 showed "Res (R1) fell out of bed onto the floor after CNA raised bed and went to get hoyer (lift) from res (R1) bathroom. Res hit head and staples were put in at ER (emergency room)."

On May 6, 2016 at 1:15 PM E1 (Assistant Director of Nurses) stated, "The nurses fill out an occurrence form after a reportable incident and the Director of Nurses(DON) sends them to IDPH (Illinois Department of Public health). We can't find the report for (R1)." E1 said a reportable incident is one that causes an injury and needs outside medical intervention.

On May 10, 2016 at 1:25 PM, E11 (DON) stated it is facility policy to send an incident report to IDPH on all serious occurrences requiring "more than first aid attention." E11 said a report should be sent within 24 hours of an incident. E11 stated, "I have nothing" and could not provide documentation that an incident report was sent to IDPH with 24 hours of R1's injury.

The facility's Occurrence Reporting Policy and

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S9999	Continued From page 2	S9999		

Procedure for Residents form dated January 2008 states, "The Resident Occurrence Report is reviewed by the Nursing Office. IDPH is notified of all serious occurrences."

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. This REQUIREMENT was not met as evidenced by:
Based on interview and record review, the facility failed to provide supervision to prevent a resident from rolling out of a bed in the high position. This applies to 1 of 3 residents (R1) reviewed for nursing care in the sample of 3.
The findings include:
R1's Problem List of February 27, 2016 showed diagnoses of Alzheimer dementia and cerebrovascular accident, was nonverbal and required full assistance with ADLs (activities of daily living). R1's Fall Risk Assessment of

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S9999	Continued From page 3	S9999		

January 21, 2016 showed a high risk level and a fall reduction approach "bed in lowest position when resident in bed" . R1's Resident Care Guide of January 21, 2016 showed difficulty with short and term memory, unable to follow directions, and staff assistance for hygiene/dressing. The Care Guide also showed a transfer need of "mechanical lift with two person assist" and "keep bed in the lowest position".
On May 6, 2016 at 1:15 PM, E2 Certified Nurse Aide (CNA) stated she was rolling R1 from side to side while dressing her in bed on April 13, 2016. E2 said she took care of R1 "a lot, knew her needs pretty well, and knew she was a fall risk". E2 said she was the only staff present in R1's room while assisting her on April 13, 2016. E2 stated, "She (R1) was flaying her legs a lot while I was dressing her and 'like kicking or jerking' which was typical for her." E2 stated she stepped away from R1's bed, "I turned my back to get the Hoyer (mechanical lift) out of the bathroom when I heard her fall out of bed and onto the floor. Her head was bleeding." E2 stated, "She (R1) was lying down in the bed when I walked away from her, but usually someone is with her, by her side when we (CNAs) get the lift out of the bathroom."
On May 6, 2016 at 12:20 PM, E3 Registered Nurse (RN) said, "She (R1) required a Hoyer (mechanical lift) and two aides to transfer her. The aides usually go in as a pair. Her partner (E2's partner) was in another resident room. The (lifts) are kept in the residents' bathrooms. Sometimes she (R1) could turn herself and move her legs. I'm guessing she just rolled out of bed."
On May 6, 2016 at 2:20 PM, E4 CNA said all residents with a high fall risk level should be monitored more closely, never left alone in a bed if they can roll, and the bed should be in the low position if the resident is in the bed.
On May 6, 2016 at 8:45 AM, E7 Licensed

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S9999	Continued From page 4	S9999		

Practical Nurse (LPN) said nurses relay resident care needs to the CNAs daily, at every shift change, and on care charts posted on the wall in residents' bathrooms. At 10:30 AM, E6 CNA stated similar knowledge relating to resident specific care needs.

On May 6, 2016 at 2:00 PM, E10 LPN said staff should never walk away from a high fall risk resident while in bed, unless all fall interventions are in place. E10 there is always the potential for a resident to roll out of the bed.

R1's Resident Care Guide Addendum dated April 13, 2016 showed "Res (R1) fell out of bed onto the floor after CNA raised bed and went to get hoyer (lift) from res (R1) bathroom. Res hit head and staples were put in at ER (emergency room)."

The facility's Resident Falls Policy and Procedure form dated December 2008 shows, "Residents who have been identified at risk for falls upon admission will have care guide approaches/interventions to decrease the risk for injuries and accidents from falls."

(B)