

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2017</b>
--	--	---	---

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

(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	<p><b>Final Observations</b></p> <p>Statement of Licensure Violation:</p> <p>300.1210d)6</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT was not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure the safety of a resident totally dependent on staff for transfers during a mechanical sling lift transfer.</p> <p>This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 4.</p> <p>The findings include:</p> <p>R1's Resident Information record shows she was admitted to the facility on July 1, 2011 and has diagnoses including Alzheimer's, and osteoporosis. R1's Restorative Nursing</p>	S9999	<p><b>Attachment A</b></p> <p><b>Statement of Licensure Violations</b></p>	
-------	--	-------	--	--

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2017</b>
--	--	--	---

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

(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	<p>Continued From page 1</p> <p>Assessment with a revision date of January 1, 2017 shows she is non-ambulatory and requires total assistance with a lift for transfers. R1's Braden Risk Assessment (pressure ulcer risk assessment) last dated January 15, 2017 shows her mobility is very limited and she is not able to make frequent or significant changes in body or extremity position independently.</p> <p>On April 4, 2017 at 8:20 AM, R1 was sitting in a high back wheel chair, in a sitting area on the East wing. R1 had a healing laceration on the right side of her forehead measuring about 1 centimeter (cm) and another healing laceration located mid forehead at the hair line extending approximately 4 cm back towards the top of the head. R1 did not respond when spoken to.</p> <p>On April 4, 2017 at 2:05 PM, E10 (Registered Nurse-RN) said E5 CNA (Certified Nursing Assistant) came to her on March 23, 2017 at 4:25 PM and told her that R1 was on the floor. E10 said she went into R1's room and saw the mechanical lift had tipped over and R1's upper body was on the metal part that the sling hooks onto. E10 said R1 hit her head and was bleeding so 911 was called. E10 said both CNAs (Certified Nursing Assistants) told her they were trying to turn R1 to put her in her chair and the entire mechanical lift tipped on it's side.</p> <p>On April 4, 2017 at 3:10 PM, E5 CNA said she was moving the mechanical lift closer to R1's wheel chair stating, "We (E4 and E5) turned her together to put her in the wheel chair. As we were turning her the mechanical lift was falling to the left. There were 2 bed side tables and when she fell she hit her head on a bed side table. She was bleeding so I gave a towel to (E4) and went to get the nurse..I think when we were turning her the</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6006738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  C 04/04/2017
NAME OF PROVIDER OR SUPPLIER  OAK CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 2</p> <p>weight all went to one side and caused it to tip."</p> <p>On April 4, 2017 at 4:02 PM, E4 CNA said she was guiding R1 while E5 CNA was operating the mechanical lift. E4 stated, "(E5) was trying to get (R1) into her wheel chair. I don't know if the legs of the (mechanical lift) got stuck in the wheels of the wheel chair. I don't know what happened. We both turned (R1). E5 turned the (mechanical lift) and I turned the sling to position (R1) towards the chair. (R1) was up in a high position. I thought (E5) was going to start lowering (R1) down. I looked up and the (mechanical lift) was tipping. E4 said it was right after they turned R1 that the mechanical lift tipped onto it's side.</p> <p>On April 4, 2017 at 8:50 AM, E2 said staff had not voiced any concerns prior to the incident occurring of any mechanical lifts almost tipping during any resident transfers. E3 (Assistant Director of Health Care Services-ADON) said when the incident happened E4 and E5 were the only ones in the room with R1. E3 said the CNAs told her that they were transferring R1 from her bed to her wheel chair. E4 who was the support person turned R1, then walked around R1's chair and when she looked up, the lift was tipping. E3 said E5 told her she felt the lift tipping and tried to stabilize it but there was too much momentum and she could not stop it.</p> <p>On April 4, 2017 at 3:30 PM, R4 said she has neuropathy and some of the CNAs run her feet into the cabinets and furniture. R4 said she does not know if she would say that the mechanical lift almost tipped over, but some of the times it is very one sided. R4 said she had her shower today and the sling was very uneven under her. R4 said some times she does not feel safe during the transfers.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2017</b>
--	--	---	---

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

(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	<p>Continued From page 3</p> <p>On April 4, 2017 at 2:15 PM, Z1 (Customer Service Personnel for the mechanical lift company) said typically when a machine like that tips over due to mechanical failure it is a leg bolt braking or coming off. Z2 (Technical Service Manager and Quality Assurance Personnel for the mechanical lift company) said the only machine issue that would cause it to tip would be a broken, missing, or loose leg bolt. Z2 said the lift in question is a 2016 model and he has only seen bolts break that are about 15 years old. Z2 said other things that could cause the lift to tip that are not due to machine failure include: there could be something on the floor and the machine is not rolling properly, if the staff push and pull on the boom sideways, if staff push on the resident instead of the lift handle bars, or if it was on uneven flooring.</p> <p>The facility's Resident Occurrence document of March 23, 2017 shows R1 fell from a mechanical sling lift during a transfer. The document shows R1 was sent to a local hospital. The CNA Post-Incident Review dated March 23, 2017, filled out by E4 and E5 shows "This happened while we were turning her to position her entire body to the chair, the (mechanical lift) went off-balance and she fell."</p> <p>R1's March 28, 2017 Resident Care Guide Adendum shows "Resident fell during (mechanical lift) transfer on March 23, 2017 due to (mechanical lift) tipped over. Transferring from bed to wheel chair. Review (mechanical lift) practice with CNAs involved to determine practice that may have contributed to fall."</p> <p>The March 23, 2017 Discharge Order Summary from a local hospital emergency department</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2017</b>
--	--	--	---

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

(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	<p>Continued From page 4</p> <p>shows R1 was seen for lacerations and contusions of head, staples were applied and R1 was discharged back to the facility on March 23, 2017.</p> <p>The facility's General Safety Guidelines last revised February 2008, reviewed January 2016 shows "11. Always use two staff to carry out a (mechanical) full body lift transfer, one staff member should keep hands on resident at all times during (the) transfer."</p> <p>The mechanical lift manual titled, "Care Lift Operations" shows "To properly move machine, stand behind machine and push on handlebars. Never push, pull or put lateral pressure on lift boom or patient."</p> <p style="text-align: center;">(B)</p>	S9999		
-------	--	-------	--	--