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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual certification survey and Change of Ownership.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		12/13/11

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
	145804	A. BUILDING _____ B. WING _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure 1. Background checks were performed on CNA's (certified nurses aides - E7, E8, E9, E10, and E11) within 10 days of hire. 2. Reference checks were performed on all CNA's before date of hire. The findings include: On 12/1/11 during review of the health care worker background check with E12 (Human Resource Manager) 10 employee CNA files were reviewed. Of the 10 files reviewed, 5 of the 10 were found with background checks that were not initiated within 10 days of the CNA hire. The initiation of the late background checks ranged from weeks to months after hire date. Two of the 5 files with late background checks were also found with no reference checks done to ensure the CNA's had worked in a CNA position within the last 2 years. Interview with E12 on 12/1/11 noted E12 to say, "I don't know why the background checks were done late. They should be done within 10 days of hire. The reference checks also should be done before the new employee is hired."	F 225		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		12/16/11

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 309	Continued From page 2 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview facility failed to: 1. Assure that 1 of 1 facility residents (R2), with a peripherally inserted central catheter (PICC) receive proper care and treatment of the PICC line. 2. Assure that all nurses are trained and competent in care of PICC lines. 3. Develop and implement a thorough and comprehensive policy and procedure using current standards of practice for care and maintenance of PICC lines. 4. Utilize and make readily available to nursing staff contracted pharmacy and infusion therapy services PICC line care policies. 5. Ensure care plans were specific and complete and necessary information was exchanged between the facility and the outside entity providing dialysis services in the facility. (R3 and R4) These failures resulted in R2 requiring emergency hospitalization 12/01/11 related to the development of a Deep Vein Thrombosis (DVT), in the left upper extremity and febrile state with etiology to be determined.	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	**250 VILLAGE DRIVE DOWNERS GROVE, IL 60516**

(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) COMPLETION DATE
F 309	Continued From page 3 This is for 3 residents (R2,R3 and R4) in the sample of 10. The findings include: Review of R2's admission face sheet and nursing documentation showed R2 was admitted to facility 11/22/11 for skilled therapy after a gall bladder surgery. During the 11/29/11 initial tour R2 was observed at her bedside with a left upper arm PICC line in place in which she was receiving Total Parenteral Nutrition (TPN), with 20% Lipids at 73 cc/ hour. R2 appeared uncomfortable and weak begging to be put back to bed. R2's left arm and hand appeared extremely swollen. R2's left arm was observed lying directly on the bed mattress and not elevated. R2 voiced that she had no pain in the left arm and that she thinks the swelling is from the IV fluids she was receiving. The PICC line insertion site was covered with a gauze pad. The dressing at the PICC line site was dated 11/24/11. The PICC line insertion site was not visible under the 2 x 2 inch gauze pad. R2's spouse was at the bedside and stated that he was very worried about R2's lack of improvement and weakened state. R2's November 2011 treatment administration record (TAR) dated November 22 was reviewed. The following was noted: 11/29/11 nursing progress notes and admission nursing assessments failed to include a comprehensive assessment of PICC line site (no	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	**250 VILLAGE DRIVE DOWNERS GROVE, IL 60516**

(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) COMPLETION DATE
F 309	Continued From page 4 arm circumference, PICC line catheter length or site description), therefore; this was not included on the TAR. TAR documented that the PICC line dressing was changed 11/23/11 and 11/30/11. R2's 11/22/11 hospital transfer form included that the PICC line was inserted on 11/16/11 and the hospital records documented the presence of an enlarging Abdominal Aortic Aneurysm (AAA), that requires surgical repair in the next couple weeks, as soon as more nutritionally stable. The first entry by R2's physician (Z2), regarding the left arm swelling was on 11/28/11. Z2's 11/28/11 progress note included "I got call over the weekend about patients PICC line problem, edema to upper extremity, 11/25/11 venous doppler negative for DVT". R2's 11/22, 11/23, 11/24 and 11/25/11 nurses progress notes include "left arm edema 2+". R2's 11/25/11 venous doppler of left upper extremity impression states: "The internal jugular, subclavian, axillary, brachial, radial and ulnar veins of left arm reveals dampened flow with poor augmentation, however there is not any definite evidence for DVT at this time. It's clinically desired for further evaluation suggest for CT venogram or magnetic resonance venogram." R2's 11/28/11 and 11/29/11 nursing progress note now shows "3+" edema of left arm. R2's 11/30/11 nursing progress note includes that	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	**250 VILLAGE DRIVE DOWNERS GROVE, IL 60516**

(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) COMPLETION DATE
F 309	Continued From page 5 the left arm is more swollen than before. PICC line intact, no complaint of pain or discomfort. R2's physician orders (POS), include a 11/25 and 11/30/11 phone order for a venous doppler of the left arm to rule out DVT. On 12/01/11 at 11:40 AM E 5 (R2's 11/30 and 12/01/11 nurse), stated that the 11/30/11 MD order for the venous doppler was written in error, it was a duplicate to the one written 11/25/11. E5 also said that on 11/30/11 she called Z2 about R2's left upper arm increasing in size. On 12/01/11 E3 (DON) and E5 stated that on 11/30/11 evening ,after E3 (DON), was questioned about the lack of R2's PICC line assessment, the initial arm circumference was taken on R2's upper left arm. E5 said that on 11/30/11 Z2 gave orders to include to notify him if arm circumference increases 2 inches or more. R2's 11/30/11 5 PM physician order includes elevate left arm at all times, apply cold compress on left upper arm twice a day as needed, measure arm circumference every shift and an out patient CT Venogram. On 12/01/11 R2 was observed in bed very tired and weak with her left arm resting next to her on a flattened pillow and not elevated. R2 had not received any cold compresses as of yet and was now complaining of severe pain when her left arm is even barely touched. On 12/01/11 R2 was sent out to the hospital for an out patient CT venogram. On 12/02/11 at 10 AM E3 stated that R2 was sent	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 309	Continued From page 6 to the emergency room from X-ray for the CT Venogram. R2 was admitted to the hospital with diagnosis of DVT to the left arm. R2's 12/01/11 emergency room report included diagnosis of Left arm DVT. Temperature 100.3 orally, pulse 118/ minute "sinus tachycardia" and B/P 154/84. Impression and plan : "Patient presents because of DVT secondary to hyperalimentation of her left arm. This line was discontinued and heparin per DVT protocol has been ordered. In addition patient is noted to have a fever. The chest x-ray which was unchanged from previous demonstrating possible heart failure. Admitting diagnosis DVT of left upper extremity, febrile illness etiology to be determined, sacral decubiti, malnutrition, anemia and depression. R2 has a prior history of DVT and Pulmonary edema, possible pneumonia and AAA. On 11/29/11 the facility's PICC line policy and procedure dated 10/11/11 was reviewed. This policy included: #8 d = assess catheter site for erythema, swelling, tenderness, which may indicate infection or catheter leakage. #14 = assess catheter site every shift and as needed for redness, drainage, tenderness or catheter migration and document. (No documentation found to validate these assessments). #10 = Apply transparent occlusive dressing and tape securely. As noted above, on 11/29/11 R2 was observed with a gauze pad over the PICC line insertion site.	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 309	Continued From page 7 On 12/01/11 E3 provided a 11/30/11 up-dated PICC line policy. This up-dated policy included: #8e Mid arm circumference on PICC or mid line site will be measured when clinically indicated as ordered by the MD. Clinical indications could be edema, swelling and other conditions specified by MD. #8f RN will notify MD of changes in mid arm measurement according to set parameter. On 12/01/11 E3 stated not all of facility nurses (RN), have been trained and competency evaluated on PICC line care. E3 said she has set up an inservice for nursing supervisors to be trained on 12/06/11 by pharmacy infusion therapy staff. The trained supervisors will train the staff RN's. On 12/02/11 E3 said that facility did not have a copy of the pharmacy infusion therapy protocol for PICC line care but that the pharmacy will be sending it by fax today. The protocol was received by fax on 12/02/11 at 1:23 PM. In addition R2's current care plan did not include care and maintenance of the PICC line or about her enlarged AAA. According to the medical record R3 is a 44 year old male who was admitted to the facility on 10/24/11 with diagnoses including ESRD (End Stage Renal Disease). R3 resides on the 3rd floor of the facility and receives dialysis 3 times per week at the in-house dialysis room located on the 2nd floor. R3's Dialysis Communication Reports in the medical record were reviewed. The communication reports contain a section to be completed by the facility nurse prior to the	F 309		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 309	Continued From page 8	F 309		

treatment and a section for the dialysis nurse to fill out pre and post treatment. The information in the first section (to be completed by the facility nurse) includes code status, medications given 6 hours prior to dialysis, meal eaten, mental status, bleeding after last treatment, chest pain, nausea/vomiting, hospitalization/procedure, anticoagulation therapy, medication held, vital signs, blood glucose, any insulin given and antibiotics given (if applicable). Seven of R3's Communication Reports were reviewed ; 10/26/11, 11/07/11, 11/09/11, 11/11/11, 11/14/11, 11/18/11 and 11/21/11. None of the pre-dialysis information was completed.

Z1 (dialysis nurse) was interviewed on 11/30/11 at approximately 3 PM in the dialysis room. Z1 stated that the Communication report is the only document that arrives with the resident prior to dialysis. Z1 further stated that the facility nurse is supposed to fill out the first section of the communication report. R3's care plan provided by the facility did not address the specific location and monitoring of R3's dialysis site. On 12/02/11 E6 (care plan coordinator) provided an updated copy of R3 ' s care plan .Added to the care plan was an intervention to "maintain the patient's dialysis site per protocol". The facility's policy on Hemodialysis Services was reviewed and does not reference the monitoring of a resident's dialysis site. E1 (administrator) stated on 12/02/11 that the facility does not have a written protocol for the monitoring and care of a resident's dialysis site.

R4 is an 80 year old male who was admitted to the facility on 10/28/11 with diagnoses including ESRD. R4 also resides on the 3rd floor of the

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 309	Continued From page 9 facility and receives dialysis 3 times per week at the in-house dialysis unit located on the 2nd floor. R4 was observed receiving dialysis on 11/30/11 at approximately 2 PM. R4 ' s communication reports were reviewed for the following dates: 11/09/11, 11/11/11, 11/14/11, 11/16/11, 11/18/11, 11/21/11 and 11/23/11. The pre-dialysis section to be completed by the facility nurse was blank for all the above dates except for 11/23/11. R4 ' s care plan reviewed on 12/02/11 notes to " monitor dialysis site and refer to MD for undue signs and symptoms. " No specific monitoring instructions for R4,s dialysis site were included in the plan.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility: 1. Failed to provide supervision to 1 resident (R10) to prevent R10 from sustaining falls and injuries. As a result of this failure R10 had 3 falls in Oct. 2011 and sustained a contusion and a right eyebrow laceration. This is for 1 resident in a sample of 10.	F 323		12/14/11

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 323	Continued From page 10	F 323		

2. Failed to ensure the residents environment remains free of accident hazards by ensuring oxygen cylinder tanks and liquid oxygen was secured while in the oxygen storage room. This was observed on 1 of 4 days of the survey.

The findings include:

1. Review of R10's closed record admission face sheet showed R10 was admitted to the facility on 8/20/11 with diagnoses including CVA (cerebral vascular accident), Hypertension, and Muscle Weakness. R10's 14 day MDS (minimum Data Set) CAA (care area assessment) documentation dated 8/30/11 showed prior to admission, R10 was found on the floor in her apartment after having a stroke. R10's fall risk assessment dated 8/20/11 showed R10 was at high risk for falls. Review of a "Fall Tool Risk" form for R10 dated 10/06/11 showed "R10 needs supervision and chair alarm on."

Review of the facility's incidents for R10 showed the following:

10/06/11 - 12:19 p.m. Found laying on floor on side. To ER (emergency room) for eval. No injury.

10/12/11 - 12:30 p.m. Found outside of room on floor with chair alarm sounding. To ER. (ER documentation showed R10 with diagnosis of contusion).

10/21/11 - 06:50 a.m. Found on floor in hallway after leaving dining room. Laceration to right brow 0.5 cm. To ER.

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 323	Continued From page 11 Nursing documentation showed with each fall incident R10 was leaving the facility dining room and going back to her room. Interview with E3 (Director of Nursing) on 12/1/11 noted E3 to say, "The dining room is supposed to be supervised by nursing staff when residents are present during meals." When E3 was asked how R3 could leave the dining room and return to her room without being noticed when the dining room was supervised; no answer was given. Further review of nursing documentation showed there was no follow up documentation regarding R10's contusion she received after the fall on 10/12/11. There was no follow up documentation after R10 returned from the hospital. There was no mention of a contusion noted in any of R10's nurses notes. There was no follow up documentation of the laceration R10 sustained to her right brow area on 10/21/11. The only documentation noted on the laceration was documentation when R10 first sustained the laceration. No documentation was noted as to the treatment received at the hospital and/or the condition of the site upon return from the hospital. Further review of incident documentation and investigations showed no analysis of the data gathered (such as the time of R10's falls, the fact that R10 was returning to her room from the dining room, etc...) on R10 to assess the circumstances surrounding R10's falls.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		12/15/11

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 431	Continued From page 12 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to :	F 431		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 431	Continued From page 13 - assure open vials of multi-use medications (Pneumovax and Tubersol) are labeled with date open in 2 of 2 medication rooms in the certified section of the facility (3A and 3B units). - timely identification and disposition of expired and discontinued medications and Intravenous solutions in 1 of the 2 medication rooms on the certified section of the facility (3B). Findings include; During the initial tour of the certified section of the facility on 11/29/11 with E3 (DON), the following was observed in the 3A and 3B medication rooms: 3A = An open vial of Tubersol dated 10/06/11 and 9 un-opened vials of Pneumovax expiring 11/24/11 stored in the medication refrigerator. 3B = An un-dated open multi-use vial of Tubersol in the medication refrigerator. 10 bottles of IV solutions dated expired between 6/2011 and 10/2011 intermingled with current un-expired IV solution bottles on the medication room shelves. 3 bottles of expired liquid stock medications (Metoclopramide, Centamin and Thera Plus), these medications were labelled expired between 4/2011 and 11/2011 and intermingled with other stock medication supply. In a pink wash basin on the counter near the sink were medications that had been discontinued for current residents (R2 and R3) and multiple discharged residents (11, R12, R13, R14, R15, R16 and R17). The discharged residents were discharged	F 431		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 431	Continued From page 14 between 5/06/11 and 11/04/11. On 11/29/11 E3 stated that facility nurses are to destroy all discontinued or discharged resident medications. E3 said that facility does not send them back to pharmacy for crediting of resident accounts.	F 431		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee file review and interview the facility failed to ensure all CNA's received 12 hours of inservice training per year. The findings include: On 12/1/11 during the Health Care Worker Background Check with E12 (Human Resource Manager), the inservice training was checked on CNA's to ensure the CNA's received 12 hours of	F 497		12/14/11

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F 497	Continued From page 15 inservice training per year. Review of E9's (Part time CNA) file showed E9 was hired at the facility on 8/10/10. E9's yearly inservice training showed E9 had only received 4 hours of inservice training from 8/10/10 to 8/10/11. Interview with E12 noted E12 to say, "E9 does have only 4 hours of inservice training from her hire date of 8/10/10 to 8/10/11. She should have at least 12 hours of inservice training."	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 16 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirement were not met as evidenced by: Based on observation, record review and interview facility failed to: 1. Assure that 1 of 1 facility residents (R2), with a peripherally inserted central catheter (PICC) receive proper care and treatment of the PICC line. 2. Assure that all nurses are trained and competent in care of PICC lines. 3. Develop and implement a thorough and comprehensive policy and procedure using current standards of practice for care and maintenance of PICC lines. 4. Utilize and make readily available to nursing staff contracted pharmacy and infusion therapy services PICC line care policies. 5. Ensure care plans were specific and complete and necessary information was exchanged between the facility and the outside entity	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 17 providing dialysis services in the facility. (R3 and R4) These failures resulted in R2 requiring emergency hospitalization 12/01/11 related to the development of a Deep Vein Thrombosis (DVT), in the left upper extremity and febrile state with etiology to be determined. This is for 3 residents (R2,R3 and R4) in the sample of 10. Findings: Review of R2's admission face sheet and nursing documentation showed R2 was admitted to facility 11/22/11 for skilled therapy after a gall bladder surgery. During the 11/29/11 initial tour R2 was observed at her bedside with a left upper arm PICC line in place in which she was receiving Total Parenteral Nutrition (TPN), with 20% Lipids at 73 cc/ hour. R2 appeared uncomfortable and weak begging to be put back to bed. R2's left arm and hand appeared extremely swollen. R2's left arm was observed lying directly on the bed mattress and not elevated. R2 voiced that she had no pain in the left arm and that she thinks the swelling is from the IV fluids she was receiving. The PICC line insertion site was covered with a gauze pad. The dressing at the PICC line site was dated 11/24/11. The PICC line insertion site was not visible under the 2 x 2 inch gauze pad. R2's spouse was at the bedside and stated that he was very worried about R2's lack of improvement and weakened state.	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 18	F9999		

R2's November 2011 treatment administration record (TAR) dated November 22 was reviewed. The following was noted:

11/29/11 nursing progress notes and admission nursing assessments failed to include a comprehensive assessment of PICC line site (no arm circumference, PICC line catheter length or site description), therefore; this was not included on the TAR.

TAR documented that the PICC line dressing was changed 11/23/11 and 11/30/11.

R2's 11/22/11 hospital transfer form included that the PICC line was inserted on 11/16/11 and the hospital records documented the presence of an enlarging Abdominal Aortic Aneurysm (AAA), that requires surgical repair in the next couple weeks, as soon as more nutritionally stable.

The first entry by R2's physician (Z2), regarding the left arm swelling was on 11/28/11. Z2's 11/28/11 progress note included "I got call over the weekend about patients PICC line problem, edema to upper extremity, 11/25/11 venous doppler negative for DVT".

R2's 11/22, 11/23, 11/24 and 11/25/11 nurses progress notes include "left arm edema 2+".

R2's 11/25/11 venous doppler of left upper extremity impression states:
"The internal jugular, subclavian, axillary, brachial, radial and ulnar veins of left arm reveals dampened flow with poor augmentation, however there is not any definite evidence for DVT at this time. It's clinically desired for further evaluation

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 19	F9999		

suggest for CT venogram or magnetic resonance venogram."

R2's 11/28/11 and 11/29/11 nursing progress note now shows "3+" edema of left arm.

R2's 11/30/11 nursing progress note includes that the left arm is more swollen than before. PICC line intact, no complaint of pain or discomfort.

R2's physician orders (POS), include a 11/25 and 11/30/11 phone order for a venous doppler of the left arm to rule out DVT.

On 12/01/11 at 11:40 AM E 5 (R2's 11/30 and 12/01/11 nurse), stated that the 11/30/11 MD order for the venous doppler was written in error, it was a duplicate to the one written 11/25/11. E5 also said that on 11/30/11 she called Z2 about R2's left upper arm increasing in size.

On 12/01/11 E3 (DON) and E5 stated that on 11/30/11 evening ,after E3 (DON), was questioned about the lack of R2's PICC line assessment, the initial arm circumference was taken on R2's upper left arm. E5 said that on 11/30/11 Z2 gave orders to include to notify him if arm circumference increases 2 inches or more.

R2's 11/30/11 5 PM physician order includes elevate left arm at all times, apply cold compress on left upper arm twice a day as needed, measure arm circumference every shift and an out patient CT Venogram.

On 12/01/11 R2 was observed in bed very tired and weak with her left arm resting next to her on a flattened pillow and not elevated. R2 had not

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	**250 VILLAGE DRIVE DOWNERS GROVE, IL 60516**

(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) COMPLETION DATE
F9999	Continued From page 20 received any cold compresses as of yet and was now complaining of severe pain when her left arm is even barely touched. On 12/01/11 R2 was sent out to the hospital for an out patient CT venogram. On 12/02/11 at 10 AM E3 stated that R2 was sent to the emergency room from X-ray for the CT Venogram. R2 was admitted to the hospital with diagnosis of DVT to the left arm. R2's 12/01/11 emergency room report included diagnosis of Left arm DVT. Temperature 100.3 orally, pulse 118/ minute "sinus tachycardia" and B/P 154/84. Impression and plan : "Patient presents because of DVT secondary to hyperalimentation of her left arm. This line was discontinued and heparin per DVT protocol has been ordered. In addition patient is noted to have a fever. The chest x-ray which was unchanged from previous demonstrating possible heart failure. Admitting diagnosis DVT of left upper extremity, febrile illness etiology to be determined, sacral decubiti, malnutrition, anemia and depression. R2 has a prior history of DVT and Pulmonary edema, possible pneumonia and AAA. On 11/29/11 the facility's PICC line policy and procedure dated 10/11/11 was reviewed. This policy included: #8 d = assess catheter site for erythema, swelling, tenderness, which may indicate infection or catheter leakage. #14 = assess catheter site every shift and as needed for redness, drainage, tenderness or catheter migration and document. (No documentation found to validate these assessments).	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 21 #10 = Apply transparent occlusive dressing and tape securely. As noted above, on 11/29/11 R2 was observed with a gauze pad over the PICC line insertion site. On 12/01/11 E3 provided a 11/30/11 up-dated PICC line policy. This up-dated policy included: #8e Mid arm circumference on PICC or mid line site will be measured when clinically indicated as ordered by the MD. Clinical indications could be edema, swelling and other conditions specified by MD. #8f RN will notify MD of changes in mid arm measurement according to set parameter. On 12/01/11 E3 stated not all of facility nurses (RN), have been trained and competency evaluated on PICC line care. E3 said she has set up an inservice for nursing supervisors to be trained on 12/06/11 by pharmacy infusion therapy staff. The trained supervisors will train the staff RN's. On 12/02/11 E3 said that facility did not have a copy of the pharmacy infusion therapy protocol for PICC line care but that the pharmacy will be sending it by fax today. The protocol was received by fax on 12/02/11 at 1:23 PM. In addition R2's current care plan did not include care and maintenance of the PICC line or about her enlarged AAA. According to the medical record R3 is a 44 year old male who was admitted to the facility on 10/24/11 with diagnoses including ESRD (End	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 22 Stage Renal Disease). R3 resides on the 3rd floor of the facility and receives dialysis 3 times per week at the in-house dialysis room located on the 2nd floor. R3's Dialysis Communication Reports in the medical record were reviewed. The communication reports contain a section to be completed by the facility nurse prior to the treatment and a section for the dialysis nurse to fill out pre and post treatment. The information in the first section (to be completed by the facility nurse) includes code status, medications given 6 hours prior to dialysis, meal eaten, mental status, bleeding after last treatment, chest pain, nausea/vomiting, hospitalization/procedure, anticoagulation therapy, medication held, vital signs, blood glucose, any insulin given and antibiotics given (if applicable). Seven of R3's Communication Reports were reviewed ; 10/26/11, 11/07/11, 11/09/11, 11/11/11, 11/14/11, 11/18/11 and 11/21/11. None of the pre-dialysis information was completed. Z1 (dialysis nurse) was interviewed on 11/30/11 at approximately 3 PM in the dialysis room. Z1 stated that the Communication report is the only document that arrives with the resident prior to dialysis. Z1 further stated that the facility nurse is supposed to fill out the first section of the communication report. R3's care plan provided by the facility did not address the specific location and monitoring of R3's dialysis site. On 12/02/11 E6 (care plan coordinator) provided an updated copy of R3 ' s care plan .Added to the care plan was an intervention to "maintain the patient's dialysis site per protocol". The facility's policy on Hemodialysis Services was reviewed and does not reference the monitoring of a resident's dialysis site. E1 (administrator) stated on	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 23 12/02/11 that the facility does not have a written protocol for the monitoring and care of a resident's dialysis site. R4 is an 80 year old male who was admitted to the facility on 10/28/11 with diagnoses including ESRD. R4 also resides on the 3rd floor of the facility and receives dialysis 3 times per week at the in-house dialysis unit located on the 2nd floor. R4 was observed receiving dialysis on 11/30/11 at approximately 2 PM. R4 ' s communication reports were reviewed for the following dates: 11/09/11, 11/11/11, 11/14/11, 11/16/11, 11/18/11, 11/21/11 and 11/23/11. The pre-dialysis section to be completed by the facility nurse was blank for all the above dates except for 11/23/11. R4 ' s care plan reviewed on 12/02/11 notes to " monitor dialysis site and refer to MD for undue signs and symptoms. " No specific monitoring instructions for R4,s dialysis site were included in the plan. (B) 300.1210b) 300.3240a) 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	F9999		

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 24	F9999		

care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
These requirements were not met as evidenced by:

Based on record review and interview the facility:

1. Failed to provide supervision to 1 resident (R10) to prevent R10 from sustaining falls and injuries.

As a result of this failure R10 had 3 falls in Oct. 2010 and sustained a contusion and a right eyebrow laceration. This is for 1 resident in a sample of 10.

2. Failed to ensure the residents environment remains free of accident hazards by ensuring oxygen cylinder tanks and liquid oxygen was secured while in the oxygen storage room. This was observed on 1 of 4 days of the survey.

The findings include:

1. Review of R10's closed record admission face sheet showed R10 was admitted to the facility on 8/20/11 with diagnoses including CVA (cerebral vascular accident), Hypertension, and Muscle Weakness. R10's 14 day MDS (minimum Data Set) CAA (care area assessment) documentation dated 8/30/11 showed prior to admission, R10 was found on the floor in her apartment after

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 25	F9999		

having a stroke. R10's fall risk assessment dated 8/20/11 showed R10 was at high risk for falls. Review of a "Fall Tool Risk" form for R10 dated 10/06/11 showed "R10 needs supervision and chair alarm on."

Review of the facility's incidents for R10 showed the following:

10/06/11 - 12:19 p.m. Found laying on floor on side. To ER (emergency room) for eval. No injury.

10/12/11 - 12:30 p.m. Found outside of room on floor with chair alarm sounding. To ER. (ER documentation showed R10 with diagnosis of contusion).

10/21/11 - 06:50 a.m. Found on floor in hallway after leaving dining room. Laceration to right brow 0.5 cm. To ER.

Nursing documentation showed with each fall incident R10 was leaving the facility dining room and going back to her room. Interview with E3 (Director of Nursing) on 12/1/11 noted E3 to say, "The dining room is supposed to be supervised by nursing staff when residents are present during meals." When E3 was asked how R3 could leave the dining room and return to her room without being noticed when the dining room was supervised; no answer was given.

Further review of nursing documentation showed there was no follow up documentation regarding R10's contusion she received after the fall on 10/12/11. There was no follow up documentation after R10 returned from the hospital. There was

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 _____	12/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TRACE	250 VILLAGE DRIVE DOWNERS GROVE, IL 60516

(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) COMPLETION DATE
F9999	Continued From page 26 no mention of a contusion noted in any of R10's nurses notes. There was no follow up documentation of the laceration R10 sustained to her right brow area on 10/21/11. The only documentation noted on the laceration was documentation when R10 first sustained the laceration. No documentation was noted as to the treatment received at the hospital and/or the condition of the site upon return from the hospital. Further review of incident documentation and investigations showed no analysis of the data gathered (such as the time of R10's falls, the fact that R10 was returning to her room from the dining room, etc...) on R10 to assess the circumstances surrounding R10's falls. 2. On 11/29/11 during the initial tour with E4 (executive director) and E1 (Administrator) 4 oxygen cylinders (3 of which were sitting directly on the floor behind a door that swings into the room) and one portable liquid oxygen container in the first floor oxygen storage room were observed unsecured. Interview with E1 noted E1 to say the oxygen tanks should be secured when stored in the oxygen storage room. (B)	F9999		