

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2024
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NAME OF PROVIDER OR SUPPLIER OAK TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 VILLAGE DRIVE DOWNERS GROVE, IL 60516
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A 000	Initial Comment	A 000		
	Annual Licensure Survey			
A2040	Section 295.2040 Disaster Preparedness	A2040		
	<p>This Regulation is not met as evidenced by: Type 3 Violation Section 295.2040 Disaster Preparedness</p> <p>a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment.</p> <p>b) Each establishment shall:</p> <p>1) Have a written plan for protection of all persons in the event of disasters, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall address the physical and cognitive needs of residents and include special staff response, including the procedures needed to ensure the safety of any resident. The plan shall be amended or revised whenever any resident with unusual needs is admitted. The plan shall also:</p> <p>A) provide for the temporary relocation of residents for any disaster requiring relocation;</p> <p>B) provide for the movement of residents to safe locations within the establishment in the event of a tornado warning or severe thunder</p>			

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A2040	<p>Continued From page 1</p> <p>storm warning issued by the National Weather Service;</p> <p>C) provide for the temporary relocation of residents any time the temperature in residents' bedrooms falls below 55°F for 12 hours or more as a result of a mechanical problem or loss of power in the establishment;</p> <p>D) provide for the health, safety, welfare and comfort of all residents when the heat index/apparent temperature (see Section 295. Table A), as established by the National Oceanic and Atmospheric Administration, inside the residents' living, dining, activities, or sleeping areas of the establishment exceeds a heat index/apparent temperature of 80°F;</p> <p>E) address power outages; and</p> <p>F) include contingencies in the event of flooding, if located on a flood plain.</p> <p>2) Instruct all personnel employed on the premises in the use of fire extinguishers.</p> <p>3) Post a diagram of the evacuation route and ensure that all personnel employed on the premises are aware of the route.</p> <p>4) Ensure that there is a means of notification to the establishment when the National Weather Service issues a tornado or severe thunderstorm warning covering the area in which the establishment is located. The notification mechanism must be other than commercial radio or television. Notification measures include being within range of local tornado warning sirens, an operable National Oceanic and Atmospheric Administration weather</p>	A2040		

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A2040	<p>Continued From page 2</p> <p>radio in the establishment, or arrangements with local public safety agencies (police, fire, ESDA) to be notified if a warning is issued.</p> <p>5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.</p> <p>c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to:</p> <p>1) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>2) Ensure that all personnel on all shifts are familiar with the use of the fire fighting equipment in the facility;</p> <p>3) Evaluate the effectiveness of disaster plans, procedures and training.</p> <p>d) The establishment shall conduct a tornado drill on each shift during February of each year for employees.</p> <p>e) Drills shall include residents, establishment personnel, and other persons in the establishment.</p> <p>f) Drills shall include making a general announcement throughout the establishment that a drill is being conducted or sounding an emergency alarm. Drills may be announced in</p>	A2040		

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A2040	<p>Continued From page 3</p> <p>advance to residents.</p> <p>g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply.</p> <p>h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation.</p> <p>i) Reporting Disasters</p> <p>1) Upon the occurrence of any disaster requiring hospital service, police, fire department or coroner, the establishment manager or designee must provide a preliminary report to the Department either by using the Assisted Living Complaint Registry or by fax or by electronic means. If the disaster will not require direct Department assistance, the establishment shall provide the preliminary report within 72 hours after the occurrence. This preliminary report shall include, at a minimum:</p> <p>A) name and location of establishment;</p> <p>B) type of disaster;</p>	A2040		

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A2040	<p>Continued From page 4</p> <p>C) number of injuries or deaths to residents;</p> <p>D) number of units not usable due to the occurrence;</p> <p>E) estimate of the extent of damages to the establishment;</p> <p>F) type of assistance needed, if any;</p> <p>G) other State or local agencies notified about the problem.</p> <p>2) The establishment shall submit a full written account to the Department within seven days after the occurrence, including the information specified in subsection (i)(1) of this Section and a statement of action taken by the facility after the preliminary report was filed.</p> <p>This requirement is not met as evidenced by: Based on interview and record review, the establishment failed to ensure Tornado drills were conducted in February on all shifts. This deficient practice has the probability to affect all residents.</p> <p>Findings include: An onsite visit was conducted on 11/15/24 and 11/18/24. Establishment's Fire and Tornado drills Log was reviewed. There was no tornado drill conducted in February. On 11/15/24 at 2:45pm, E1 was interviewed regarding tornado drills, E1 was not aware that Tornado drill has to be conducted in the month of February.</p>	A2040		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	<p>Continued From page 5</p> <p>This Regulation is not met as evidenced by: Type 2 violation</p> <p>Section 295.4060 Alzheimer's and Dementia Programs</p> <p>a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act)</p> <p>g) If an establishment accepts any individuals with cognitive impairments that prevent them from safely evacuating the establishment independently, sufficient staff members shall be present and awake 24 hours a day to assist in evacuation.</p> <p>h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall:</p> <p>1) Disclose to the Department and to a potential or actual resident of the establishment information as specified under the Alzheimer's Special Care Disclosure Act;</p> <p>2) Ensure that a resident's representative is designated for the resident;</p> <p>3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who:</p> <p>A) May wander; and</p>	A4060		

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A4060	<p>Continued From page 6</p> <p>B) May need supervision and assistance when evacuating the building in an emergency;</p> <p>6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times.</p> <p>These requirements were not met as evidenced by: Based on interview and record review, the establishment failed to prevent elopement by two (R2, R3) residents out of nine residents reviewed for elopement. This failure has the potential to affect all residents in the Dementia floor. Findings include: R2 is 68-year-old. R2 moved into this establishment on 4/6/2024. R2's diagnoses include but not limited to Repeated Fall, Degenerative Disease of Nervous System, Dementia, Anemia, Depressive Disorder. R2's Service Plan indicated that R2 is at high risk for elopement as evidenced by past attempts at elopement. R2's progress notes dated 7/10/2024 indicated the following: "Resident was attempting to leave the facility without proper authorization or accompaniment. Security intercepted the resident outside and safely escorted them back to the facility. Resident did not have a wander guard on, and the door alarm did not go off. No physical injuries were observed. Will continue to monitor resident."</p>	A4060		

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A4060	<p>Continued From page 7</p> <p>R3 is 83-year-old. R3 moved into this establishment on 4/17/2024. R3's diagnoses include but not limited to History of Falling, Cataract, Essential Hypertension, GERD, Hearing Loss, Lymphedema, Cellulitis, Pathological Fracture. R3's service plan indicated that R3 is at high risk for elopement as evidenced by past attempts at elopement, removal of wander guard, and verbalized intentions to leave the community. R3's progress noted dated 7/10/2024 indicated: Resident was attempting to leave the facility without proper authorization or accompaniment. Security intercepted the resident outside, and resident stated, "I was looking for my car." Resident safely escorted back to facility by security. Resident did not have a wander guard on, and the door alarm did not go off. No physical injuries were observed. Closely monitoring resident.</p> <p>9/10/2024- At approximately 6:10pm resident activated the emergency exit door located near the nursery care station and exited the building without staff awareness. The door alarm sounded, and staff responded within about 15 seconds. Upon reaching the exit, staff member disabled the alarm and did not see anyone at the exit. Shortly after, the front desk staff contacted the writer and informed them that the resident had re-entered the building by herself through the main entrance. The front desk staff confirmed the resident was safe and would be escorted back to the unit. Resident was assessed for physical and emotional injuries, and none were present. Establishment's incident report indicated that following elopement timeline.</p> <p>7/11/2024 Elopement timeline (Part 1) 7:51PM: R2 and R3 approached the memory care entry door and attempted to exit using the keypad with incorrect code. Alarm began to sound; Staff were interviewed and gave their accounts of what they</p>	A4060		

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A4060	<p>Continued From page 8</p> <p>were doing at the time of the incident.</p> <p>7:52PM, E14 (Security) opened the entry door because he heard someone attempting to leave. E14 turned off the alarm and held the door open for R2 and R3, who exited the unit.</p> <p>7:53PM- R2 and R3 arrived at the front desk and began to talk to E13 (Receptionist), which during interviewed stated that R2 and R3 said they were going out to have something to eat. At this time both R2 and R3 exited the lobby through the front door.</p> <p>7:55PM- R3 reentered the lobby. R2 did not reenter. 7:56PM- R2 reentered the lobby.</p> <p>7:57PM- R2 and R3 walked back to the Assisted Living seating area.</p> <p>8:15PM- Security guard passed R2 and R3 on the sidewalk.</p> <p>8:20PM- Security guard approaches R2 and R3 looked in the directory to find out where their appalments were located.</p> <p>8:25PM- Security guard attempted to take R3 to independent Living as R3 used to be a resident of Independent Living, but that apartment was unoccupied.</p> <p>8:35PM- R2 and R3 are returned to the Memory Care Unit.</p> <p>R3's Elopement Incident Timeline for 9/10/2024 9/11/2024 Timeline (Part 1) 6:02PM R3 attempted to exit stairwell 2 by pressing the panic exit bar for approximately 1-2 seconds. Alarm began to sound. R3 stepped away from exit door. 6:02PM Certified Nursing Assistant (CNA) responded to stairwell 2 in approximately 20 seconds. CNA silenced the alarm and redirected R3 to her room. 6:08PM R3 returned to stairwell 2 attempted to press the panic bar 6:09PM R3 exited through the exterior door of stairwell 2 and headed south on the sidewalk. Stairwell 2 alarm began to sound, CNA returned to exit door and silenced alarm. CNA looked through the exterior window to</p>	A4060		

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A4060	<p>Continued From page 9</p> <p>see if someone exited the community. At this time R3 was out of sight of CNA ...</p> <p>E10 (CNA) at the time of the incident she was providing care to another resident, she heard the alarm and came to the location of the alarm, redirected R3 and silenced the alarm. E10 heard the alarm again and was not able to respond immediately, E10 responded as soon as she could, she silenced the alarm and looked out the window to see if anyone had exited. E10 did not notify the nurse on duty.</p> <p>E11 (Licensed Practical Nurse) was the nurse on duty ...E11 said that she heard the alarm sounding before being silenced. E11 did not respond to the alarm sound.</p> <p>6:14PM R3 entered through the front entrance activating the wander guard alarm. Receptionist contacted Memory Care Nurse. 6:16PM- R3 was returned to the Memory Care Unit.</p> <p>On11/18/2024 at 8:59AM, E2(Clinical Nurse Coordinator) said that R2 is in the Memory Care, and it is a locked unit, she wandered outside the facility from Memory Care. She didn't have a wander guard and the alarm didn't go off. E2 said that everyone who is an elopement risk is supposed to have a wander guard. E2 said that R3 left the Memory Care locked unit was brought back by security said that she was looking for her car. she didn't have the wander guard; she was assessed for Elopement risk. R3's incident on 9/10/2024- E2 said that R3 exited out of the side door, alarm sounded, staff member disables the alarm and didn't see anyone at the exit, front desk alerted the nurse on duty that resident reenter the facility by herself. 6:02PM and was found at 6:14PM.</p> <p>On 11/18/2024 at 10:52AM, E1 () said that both R2 and R3 were found outside the building on the sidewalk. Both residents eloped at the same time, they are high function Memory Care residents,</p>	A4060		

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A4060	<p>Continued From page 10</p> <p>they were trying to open the door with the code, security opened the door and let them out. He didn't realize they were residents. they were found by the receptionist. The alarm didn't sound because the security opened the door. For the second time 9/10/2024 the alarm went off and the staff went to look in the surrounding area and didn't see the resident exiting.</p> <p>On 11/18/2024 at 12:00PM, E10 (CNA) said "I was assisting another resident with incontinence care. I left the room, when I heard the alarm sounded, I ran to the door, i looked around and outside and i didn't see anybody out there I silenced the alarm, and I ran back to the room to assist the resident. We are supposed to do head count when the alarm goes off. I think the nurse didn't but not sure, I believe she did."</p> <p>On 11/18/2024 at 12:04PM, attempted to interview E11 (LPN), no response to phone call. On 11/18/2024 at 12:06PM, attempted to interview E12 (CNA) no response to phone call. On 11/18/2024 at 12:08PM, E13(Receptionist) said "I was the receptionist, there was a confusion, with the residents, I was not familiar with one of them. They were outside the building and security was asked to look for them. They thought that they were visitors because they were dressed like a regular person, they were from memory care and were able to get out when someone one came out. It was a big deal people didn't realize that they were residents from the memory care. They were fairly new, then staff were not very familiar with them."</p> <p>On 11/18/2024 at 12:17PM attempted to interview E14 (Security guard) no response to phone call.</p> <p>Establishment's Policy and Procedure title Elopement, Unsupervised Absence, Hazardous</p>	A4060		

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A4060	Continued From page 11 Wandering and Missing Residents. Reviewed date 11/7/2024 indicates. Elopement Response When an elopement occurs: Once a resident has been determined to be missing, nursing team members will initiate a search of the resident's living area and common area within the immediate community ...	A4060		