STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008270	A. BUILDING: _____ B. WING _____	C 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT ELMWOOD PARK	7733 WEST GRAND AVENUE ELMWOOD PARK, IL 60707

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S 000	Initial Comments Complaint 2196253/IL137564	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care Section 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff performed an	S9999		

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S9999	Continued From page 2 assessment when resident complained of foot pain; failed to follow physician orders and ensure that urgent orders were carried out; failed to notify the physician regarding a change in condition; and failed to assess/treat arterial wounds timely. This failure applied to one (R2) of three residents reviewed for nursing care and resulted in R2's emergent transfer to a local hospital for treatment of macerated skin to second and third toes on left foot, and gangrene to third toe. Findings include: R2 is a 79 year old male with diagnosis that includes: End Stage Renal Disease, Vascular Dementia with behavior disturbance, Hypertensive Chronic Kidney Disease and Idiopathic Gout. R2's progress notes dated 8/6/21 document that R2 was at dialysis when R2 complained of bilateral foot pain. The dialysis center called the facility and reported to the nurse. These progress notes also document that on 8/11/21, R2 refused to go to dialysis because of the foot pain. On 9/9/21 at 11:43am, V3 (Wound Care Nurse) indicated that 8/19/21 was the first time that the wound care team assessed R2. V3 stated, "I was doing rounds with (V15-Wound Care Doctor) when nurse on staff came to us and said to look at (R2's) left foot and that something was going on. (V15) did assessment and ordered venous and arterial dopplers of both legs. He then ordered Betadine treatments to be done daily between 2nd and 3rd toes and medial left foot by the great toe. There was eschar (blackened areas) on toes between 2nd and 3rd digits." V3 indicated that the bilateral lower extremity venous and arterial dopplers were ordered emergently by	S9999		

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S9999	Continued From page 3	S9999		

V15 on 8/19/21. V3 stated, "Bilateral dopplers were ordered due to the necrosis and to make sure there was no blockage going on. The venous and arterial dopplers were ordered to be done STAT (right away)."
R2's medical record indicates that the arterial dopplers were not performed until 8/20/21 and the venous dopplers were not performed until 8/24/21.

R2's progress notes and diagnostic result document that on 8/25/21, R2 was diagnosed with a DVT (deep vein thrombosis) in both the right and left femoral veins. R2 was immediately sent out to a local emergency room for treatment.

R2's emergency room records document that an ultrasound was done and the results show bilateral lower extremities deep vein thrombosis, gangrene and a foul odor to the second and third toes on the left foot.

On 9/8/21 at 12:17pm, V3 (Wound Care Nurse) stated, "No one ever reported to me about (R2) having any foot pain."

On 9/9/21 at 10:16am, V16 (Diagnostic Representative) stated, "We have the order for the arterial doppler and the venous doppler but because Medicare won't approve them to be done on the same day, we had to move one to the next day. We did the arterial doppler on the (August) 20th and were supposed to do the venous doppler on (August) 21st but it wasn't done. It wasn't done on the (August) 22nd or on the 23rd. (R2) was in dialysis so we did (venous dopplers) on 8/24/21. I'm not sure why it wasn't done on the 21st."

On 9/9/21 at 12:13pm, V17 (License Practical

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S9999	Continued From page 4 Nurse - LPN) stated "Yes, I was (R2's) primary nurse. When we do assessments of residents, we document on skin assessment sheet/shower sheets. We're supposed to do skin assessments on shower days and as needed. I can't recall if I did a skin assessment on (R2's) foot." V17 continued to state, "No certified nurse assistant (CNA) reported to me (R2) had issues with his feet. He had his shoes off when I saw them." This surveyor asked V17 why there were no skin assessments done on R2's feet from the time he first complained of pain on 8/06/21 to 8/19/21, when the wound care team saw him. V17 stated, "I don't know." There were no skin assessments of R2's foot in the medical record. On 9/9/21 at 1:50pm, V15 (Wound Care Doctor) stated, "I was unaware that the diagnostic test was not done on the day that it was ordered. I ordered them stat and I expected them to call me and let me know it wasn't done. I ordered the test because (R2's) toes had necrotic tissue. It was eschar necrotic tissue. I felt it was an arterial vascular issue, that's why I ordered the arterial doppler. I ordered the venous doppler to rule out any blood clots. We use the arterial doppler to see if the extremities are getting enough blood and oxygen flow to and the venous doppler tells us if the blood is moving away from the extremities back to the heart. On (August) 19th is the first time I was made aware of (R2's) foot. The results I got back from the arterial doppler showed mild to moderate blockage. So that means that (R2's) foot was getting some type of circulation but not enough. For the toes to become gangrene, something must have happened from the time I saw him and he was sent to the hospital. Yes, the facility should have noticed any changes before they sent him out to	S9999		

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S9999	Continued From page 5 the hospital. Yes, with mild to moderate arterial blockage they had time to notice. It will start as a small little discoloration on the skin then it progresses into eschar. With venous, they have swelling and complaints of pain. They should have seen it before the 19th. It would have been noticeable. If he was having pain, they should have did a full assessment of his feet to make sure there was no swelling or wounds. It would have to be severe blockage for it to become necrotic overnight. It starts with the CNA's. If they are cleaning and looking at the patient they would see something new like discoloration or wounds. They can report it to the nurse and then she would do the full assessment of the patient. They should let me know what they found so I can see the resident and start treatment." On 9/9/21 at 2:27pm, V2 (Interim Director of Nursing) stated, "Nurses should assess whatever the patient presents with then they should check the patients diagnoses and labs then call the doctor only if they are not able to handle the issue." V2 indicated that they call the doctor, then the doctor will make the decision if it can be treated in house or if they should be sent out to the hospital. V2 stated that the diagnostic company does not do stat procedures. V2 stated, "We would have to send them to the Emergency room." V2 continued to state, "If the nurses don't get results, I expect for them to call and do a follow up to why the results were not sent. If it wasn't done they should follow up and find out when they are coming to do it. I expect them to call the doctor and let them know the test was not done and get a new order or get the okay to use the old order. (Staff should) call the diagnostic center to find out when and what time they will come out to complete the diagnostic test because it was not done on the date it was ordered. They	S9999		

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S9999	Continued From page 6 should then document stating why the test was delayed. Skin assessments are usually done on shower days after the CNA has done the shower or bath. The nurse is supposed to come in and do a head to toe assessment. If the CNA is repositioning a resident and find something they should report it right away to the nurse and then the nurse should complete the assessment." The facility submitted their policy and procedure titled, "Change in resident's condition or status" revised on 05/17 that states: Objectives - our facility shall promptly notify the resident, his or her attending physician and representative of any changes in the resident condition and or status. Procedures: 1) the nurse will notify the attending physician when: B) there is a significant change in the resident's physical, mental or psychosocial status. C) there is a need to alter the resident's treatment significantly. F) deems necessary or appropriate in the best interest of the resident. 3) except in medical emergencies, notifications will be made within twenty-four (24) hours of a change in the resident's condition or status. 5) the nurse will record in the residents medical record any changes in the resident's medical condition or status. (A)	S9999		