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	IL6006837	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS OAKTON PAVILLION	1660 OAKTON PLACE DES PLAINES, IL 60018

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S 000	Initial Comments Complaint Investigation: 2199636/IL141801	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 4) 300.1210 b) 5) 300.1210 d) 6) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and	S9999	**Attachment A** **Statement of Licensure Violations**	

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encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to provide a resident with assistance during a transfer for a resident assessed to require assistance with repositioning/transferring. This failure applied to one (R1) of three residents reviewed for assistance with transfers. This failure resulted in R1 having a fall, requiring emergent transfer to local hospital, and being diagnosed with a fractured femur.

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S9999	Continued From page 2 Findings include: R1 was admitted to the facility on 7/14/21 and has medical diagnoses that include presence of right artificial hip joint, fracture around internal prosthetic right hip joint, (subsequent encounter), osteoarthritis (right hip), chronic pain syndrome, unsteadiness on feet, difficulty in walking, aftercare following joint replacement surgery - right total hip arthroplasty, spinal stenosis, and need for assistance with personal care. 1/8/22 at 12:25pm, R1 was in R1's room in bed. R1 was alert and oriented and had a clear recollection of events related to recent fall. Surveyor was able to determine that R1 was is a reliable historian of events. R1 stated, "In October a CNA was helping me go from the walker to the wheelchair, then she left the room, and I was supposed to have someone with me at all times because I came here after hip surgery. I can't remember who the CNA was, and I don't think I've seen her since. But she came in to help me get to the bathroom and when I was done, she helped me get up and I was using the walker to get back into my wheelchair and in the middle of it she just left; she didn't say anything or tell me that she was leaving, so as I was trying to get into the wheelchair my foot hit the back of the wheelchair and I fell. I was out of it after the fall, I was so disoriented and in so much pain. I just remember hearing voices say, "Let's move (R1)" and I thought oh, no, please don't touch me because I was in excruciating pain. I knew right away that something was broken, and it turned out to be my femur on the same side where I had just had the hip surgery. I did tell the nurse that the CNA left me, and I told them (staff) when they came back to ask me what happened. I don't	S9999		

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S9999	Continued From page 3	S9999		

know why the CNA just left like that in the middle of helping me." When surveyor asked R1 if she knows how to use R1's call light and if R1 ever tries to get up on R1's own. R1 stated, "No, I never try to get up on my own. I don't want to fall again. I want to go home. I'm miserable here and it's disappointing that I was getting better and because of the fractured femur, now I have to be here longer."

Facility provided final incident report to State agency on 10/16/21 that includes:

Occurrence description:
"On October 11th at approximately 10:45am, CNA (named) had observed the resident (R1) on the floor next to the left side of (R1) bed and immediately called for the resident's nurse (named). Nurse (named) promptly proceeded to the resident's room. Resident was observed lying face towards the bathroom door and bilateral legs extended. Resident is alert, verbally responsive, and oriented x 3. Upon completion of a full body assessment, (R1) was noted with pain, slight swelling, and discoloration of the right leg, along with limited range of motion in the extremity. Nurse (named) administered PRN pain medication to help relieve discomfort. Resident was alert at (R1's) baseline. No changes in level of consciousness. No other physical injuries noted. NP (named) of primary MD (named) was notified and gave orders to send resident (R1) to (local hospital) ED for evaluation and treatment. Paramedics were called and the resident was transported as ordered at approximately 11:45am. Nurse (named) updated emergency contact of resident's status.

On October 11th at approximately 6:30pm, the facility was notified by (local hospital) that

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resident (R1) would be kept for observation overnight. At 10:51am on October 12th, the facility was notified that (R1) was diagnosed with right periprosthetic femur fracture. Administrator, MD, and Clinical team were notified.

CNA (named) was returning from a break, upon entering the floor she heard a loud noise and proceeded towards it. CNA (named) entered (R1)'s room and had observed (R1) on the floor near (R1's) bed. CNA (named) immediately notified the resident's nurse. At around 10:45 Nurse (named) was notified by CNA (named) that resident (R1) was observed on the floor on (R1's) left side of the bed. This nurse immediately went to resident's room. Prior to the incident the resident was observed in (R1's) bed watching TV. At the time of the event, resident was observed by Nurse (named) lying face towards the bathroom door and bilateral legs extended. (R1) is alert, verbally responsive and oriented x 3, which is (R1's) baseline. Per Nurse (named) the resident was then turned to (R1's) back using a log roll method with 3 staff assist. Upon assessment, the resident did not show any facial injuries - there was no swelling, bruising, and/or redness noted on (R1's) face. Resident complained of pain in the right knee, Nurse (named) noted that the range of motion to the right leg was limited and noted slightly swollen and discolored. Resident's vital signs were stable. Nurse (named) stated that (R1)'s surroundings remained clutter free, the floor was clean and dry, and the resident was observed with non-skid socks on. (R1's) wheelchair was noted to be in locked position by the right side of the bed. When Nurse (named) asked the resident how the incident occurred, (R1) stated (R1) was transferring self from the bed to (R1's) wheelchair. A head-to-toe assessment was done,

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PRN Norco 325/10 was given at 11:15am. NP from MD (named) was notified by Nurse (named) with orders to send the resident to local hospital. Nurse (named) also notified the resident's emergency contact. 911 was called and (R1) was sent to local hospital 11:45am. CNA (named) at the time of the event was assisting another resident with a call light. This CNA had rounded on the resident approximately 15 minutes prior to the event ...

Conclusion: After thorough investigation and based on observations by staff, as well as resident statement, the facility determined that the resident had attempted to get up from (R1's) bed without calling for assistance. Resident's prior diagnosis of unilateral primary osteoarthritis of the right hip, spinal stenosis, muscle weakness, difficulty walking, other lack of coordination, and unsteadiness on feet puts R1 at a high risk for a fall. Resident was assessed for injuries and pain was treated timely. Vital signs, neurological checks, and range of motion were completed. Resident was sent to (local hospital) for evaluation and treatment. Upon future return to the facility, (R1) will be monitored for pain, changes in LOC, any signs of infection, and will be evaluated by therapy for rehabilitation."

Per Administrator, the previous Director of Nursing was the person who conducted this investigation and there is no other information.

Hospital record dated 10/11/21 confirms that R1 obtained a periprosthetic fracture of the right proximal femur as a result of aforementioned fall.

R1's MDS (Minimum Data Set) Assessment dated 7/21/21 documents that R1 has a BIMS (Brief Interview of Mental Status) score of 15

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S9999	Continued From page 6 (cognitively intact) and is coded as 3/2 (extensive assistance required/one-person physical assist) for transfers. R1's current care plans include: "Problem" (R1) is limited in physical mobility, requires use of bed rails for bed mobility R/T generalized weakness, right side joint replacement of the hip. (Created: 7/15/21) "Approach" (includes and not limited to) Provide 1 person assistance for repositioning/transferring. (Created: 7/15/21) "Problem" (R1) is at risk for falling R/T ROM limitations, General muscle weakness, Right side joint replacement surgery. (Edited: 10/21/21) "Approach" (includes and not limited to) Check for toileting needs and provide assistance as needed. (Created: 7/15/2021) Care plan also includes the following information dated 10/12/21 (regarding fall): Alert and Oriented: Resident is A&O x 3. Verbally responsive ... Incontinent/continent: Incontinent ... What type of assistance needed for ADL and Transfer: Limited 1 Person Assist... Use what device to ambulate: WC, is in good working condition, able to lock and unlock WC ... Recent Administration of PRN (as needed medication): Resident Requested Norco 10-325mg was given after the fall at 11:15am ... Resident Statement: I was transferring myself from bed to WC???... Root cause: Transferring self without assistance, resident did not pull the call light at the time of fall ...	S9999		

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S9999	Continued From page 7 1/9/22 at 2:10pm, V6 (RN), who was the nurse on duty at the time of the fall on 10/11/21, stated, I don't usually work on that floor and I had recently started working at the facility, so at that time I wasn't too familiar with (R1). The CNA told me that R1 was on the floor. The resident was in so much pain that R1 couldn't answer my questions but R1 said R1 was trying to transfer self to the wheelchair. I sent R1 out to the hospital immediately after giving R1 pain medication. I asked the CNA who was assigned to work on that side where she was, and she said that (at the time of the fall) she was in another room. (R1) does normally ask for help; R1 is not like that (impulsive) and R1 knows how to use the call light. Progress Note written by V6 (RN) on 10/11/21 at 11:30AM includes: Prior to the incident resident was observed in R1's bed watching TV. At around 10:45am notified by the CNA that resident is observed on the floor. Writer immediately rushed to the resident's room and observed (R1) lying on the floor on (R1's) left side of the bed. Resident was observed lying face towards the bathroom door and bilateral legs extended. Resident is alert, verbally responsive and oriented x 3, which is (R1's) baseline. Resident was then turned to (R1's) back using log roll method with 3 staff assist ...Wheelchair was noted to be in locked position by the right side of the bed. When asked resident how did the incident occurred (R1) stated, "I was transferring myself from bed to WC." Head to toe assessment was done ... 1/9/22 at 2:46pm, V7 (CNA), who was the person who found R1 after the fall stated, I remember that day because our regular nurse was off. It was after my break around 11am and when I got off the elevator, I heard a sound like a walker	S9999		

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S9999	Continued From page 8 falling and I knew that R1 is the only person in that area who used a walker. I ran into R1's room and R1 was on the floor by R1's walker. R1 did say that somebody was helping R1, but I don't remember who it was. R1 is very, very, alert and R1 knows how to use R1's call light. R1 always calls for help when R1 needs help. R1 is very alert and R1 tells the nurse everything. Review of staffing sheet for (R1)'s unit on the date of incident 10/11/21, 7am-3pm documents that V6 (RN) was the nurse on duty and there are two CNAs assigned to the unit, V7 (CNA) and V9 (CNA). On 1/8/22, V1 (Administrator) provided surveyor with a copy of V9's (CNA) personnel file; there was no current contact information in the file. Surveyor asked to speak with V9 if at all possible. 1/10/22 at 12:58pm, V1 re-confirmed that V9 was on leave of absence. No contact information for V9 was provided. Facility provided Activities of Daily Living (ADLs) policy with a review date of May 2021 policy reads: Policy: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). To ensure that their activities of daily living (ADLs) does not diminish unless the circumstances of their clinical condition(s) demonstrate that Diminishing. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for	S9999		

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S9999	Continued From page 9 residents who are unable to carry out ADLs. independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care). b. Mobility (transfer and ambulation, including walking). c. Elimination (toileting). d. Dining (meals and snacks. e. Communication (speech, language, and any functional communication systems). "A"	S9999		