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	IL6006837	A. BUILDING: _____ B. WING _____	C 09/12/2023

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: 2397091/IL163659	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)1)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	**Attachment A** **Statement of Licensure Violations**	

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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.

6) All necessary precautions shall be taken to assure that the residents' environment remains

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S9999	Continued From page 2 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: A. Based on interview and record review the facility failed to follow the fall prevention policy to develop, implement, reevaluate the effectiveness of interventions to prevent or reduce the risk of falling for a resident with dementia, poor safety awareness, and high risk for falls. This failure affected one of three residents (R1) reviewed for fall prevention intervention. These failures resulted in R1 being involved in a fall incident causing pain to the left hip area. R1 was sent to the local hospital and evaluated and treated for a displaced left femur fracture. B. Based on interview and record review the facility failed to provide pain management after a fall for a dementia resident observed by the resident's family to have facial grimacing and acting out of character and complaining to staff of left hip pain during dressing. This affected one of three residents (R1) reviewed for pain management. This failure resulted in the staff being notified that R1 was in pain by a family member post fall and R1 not receiving any pain medication. R1 was transferred to the local hospital where R1 was diagnosed and treated with a displaced left femur fracture. Findings include:	S9999		

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S9999	Continued From page 3 R1's face sheet shows diagnosis of Parkinson's disease, Alzheimer's with late onset, tremors, abnormalities of gait and mobility, dementia. MDS dated 7.21.23 section C denotes BIMS score of 7(cognitively impaired). Section G for bed mobility denotes R1 is extensive assist with one-person physical assist, transfer denotes R1 is extensive assist with one-person physical assist. Balance during transition and walking for surface-to-surface shows 2- not steady only able to stabilize with staff assistance. Facility final investigation to the department dated 8.14.23 denotes in-part date of occurrence 8.12.23, R1 is the resident, occurrence description: R1 was found on the floor next to his bed. Bed was in lowest position R1 was unable to state what happened. R1 complaint of discomfort to the left leg on exam. Nurse on duty called medical doctor and receive orders for X-rays. While waiting for X-rays it was noted to have swelling to the left hand and fingers. Nurse on duty call medical doctor for further orders, at this time receive orders to send to Emergency department for further evaluation. Nursing on duty for follow up and was informed by hospital that R1 was being admitted with sepsis. On 8.13.2023 at approximately 9:00 PM nurse on duty also have follow up with V1 who informed nurse on duty that R1 had a hip fracture. On 8.14.2023 the nurse at the hospital who stated R1 was admitted with left intertrochanteric fracture was also admitted with sepsis full investigation to follow. Final report denotes in-part, R1 is a 75-year-old long term care resident. R1 have (sic) a history of Alzheimer's, Parkinson's osteoarthritis, anxiety depressive disorder and lumbar fracture R1 has a BIMS of 7 and is extensive assist for activity living. R1 has behavioral of whistling, shanking half rails when in	S9999		

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his room. R1 also has a behavior getting up out of bed without assistance. Interview with V2 (Certified Nurse Assistant/CNA) on 8.12.23 "I was assigned to R1, I made rounds on him around 730am." V2 states she set him (R1) up for breakfast around 8:30 am, and he ate 75%. V2 states at 10:00am R1 was observed on his back at the head of other bed in room. V2 states he (R1) awake and alert to his norm. V2 states that she then went and informed NOD (Nurse on duty) that R1 fell. They went back to his room were NOD assessed him (R1) and took vital signs. V1 states he denied pain at this time. V2 stated that about 15-20 minutes later he (R1) c/o (complained of) left leg pain. Interview with V3 on 8.12.2023 I (V3) was assigned to R1 around 10:00 AM V2 on duty informed me that R1 was on the floor in the room. When I arrived to the room R1 was on the floor next to other bed and almost sitting position. R1 was alert to his norm. Assessed him and at this time he complained of no pain or discomfort. Neuro checks done at this time and were WNL (within normal limits). R1 was assisted up and back to bed no injuries noted at this time. V3 states about 15 minutes later aide on duty inform him of pain to left hip. On assessment I noted no deformities to area MD (medical doctor) called and nurse on duty spoke with V8 (Nurse Practitioner). V8 gave orders for X-rays and labs at this time X-ray and lab notified of orders. Interview with V9 (CNA) on duty 8.12.23 was assigned to R1 from 11pm to 7:00am, states that R1 was alert to his norm during the night. That he whistled for assistance during the night, states that R1 got up during the night and was easily directed back to his bed. Interview with V10 (nurse) on 8.12.23 "I was nurse assigned to R1 from 11pm to 7:00 am. I received R1 asleep during my initial rounds." V10 states that R1 was alert to his norm. R1 had

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gotten out of bed 2-3 times during the night and was easily directed back to bed. Conclusion denotes in-part investigation included record review and interviews. The investigation reveals that R1 frequently gets up on his own and ambulates a few steps with an unsteady gait. On August 12, 2023, R1 experienced a fall while self-ambulating in the room. He was unable to express to staff what happened to cause the fall.

On 9.6.23 at 11:26am V2 (CNA) said she was assigned to work with R1 on 8/12/23 7-3:00pm shift. V2 said she assisted R1 with breakfast that morning. R1 was in the bed. V2 said she was in the room caring for another resident when the housekeeper informed her that R1 fell. V2 said when she arrived to R1's room, R1's roommate was trying to assist R1 up from the floor. V2 said she intervened. V2 said R1 was laying on the floor on his back, his head was near the roommate's bed. V2 said she went and got the nurse. The nurse arrived. R1 denied pain. The nurse assessed R1. V2 said R1 was picked up, placed back in the bed manually using a gait belt. V2 said about 15 minutes later when she was going to get R1 dressed, R1 complained of pain to the left hip. V2 said she informed V3 (Nurse) of R1 complaint of pain. V2 said she don't know if V3 gave R1 anything for pain. V2 said during her shift she informed V3 about 3 times of R1's complaints of pain. V2 said one time she informed V3, V3 said that he has to follow the doctors' orders, and the doctor an X-ray. V2 said she worked a double (3pm-11pm shift). V2 said R1 had complaints of pain during the evening shift also. V2 said she think she informed the evening nurse about 3-4 times of R1 complaint of pain. V2 said R1's daughter did visit R1 on 8.12.23. V2 said R1 did not say how he fell. R1 did not say what he was doing when he fell. V2

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said R1 has dementia. V2 said R1 bed was in a low position. R1 did not have on any shoes. R1 did not have on any skid free socks. V2 said she don't recall were R1's call light was at. V2 said R1 was a fall risk. V2 said R1's gait was not steady. V2 said R1 could transfer from bed to chair with assistant from staff.

On 9.6.23 at 10:50am V1 (R1's family) said she was informed that R1 had a fall. She visited R1 around 6:00pm on 8.12.23 and notice R1 was in pain. R1 was acting out. R1 was not being himself and R1's eyes were rolling up. V1 said she told the nurse that R1 was in pain. V1 then said she don't know if it was the nurse or CNA that she informed of R1 pain. V1 said she don't remember if R1 got something for pain.

On 9.6.23 at 1:07pm V3 (Nurse) said he was assigned to R1 on 8.12.23. V3 said it was around 10:30am when V2 informed him that R1 had fallen. V3 said when he came in the room to assess R1, R1 was on the floor, kind of near the roommate's bed in sitting position almost. V3 said when he asked R1 how he fell, R1 just shrugged his shoulders, R1 did not say anything. V3 said he figured R1 was going to look at the roommate's shoes. V3 said because R1 was near the roommate's bed he figured R1 was going to look at the roommate's shoes. V3 said R1 did not tell him that he was going to look at the roommates' shoes. V3 said he was not aware that R1 was a fall risk. V3 said he found out on the day of the fall that R1 was a fall risk. V3 said he does not know what fall precautions R1 had in place. V3 said the social worker knows what fall precautions R1 has in place. V3 said the social worker puts the fall precautions in place. V3 said when he was completing the fall assessment for R1, that when he noticed R1 had

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S9999	Continued From page 7 a fall before and that R1 was a fall risk. V3 (Nurse) said 15-20 minutes after picking R1 up after the fall V2 informed him that R1 was experiencing pain. V3 said when he assessed R1 for pain, R1 denied pain. V3 said he did not give R1 anything for pain. V3 said R1 has dementia. V3 was asked would it be reasonable to believe due to R1's dementia he may not be able to verbalize his pain during your assessment. V3 said that makes since. On 9.7.23 at 12:32pm V9 (CNA) said he did not tell the facility that R1 got up during the night shift. V9 said R1 shakes the bed rails and whistle when he wants a brief change. V9 said he did speak to the DON (Director of Nursing) or administrator regarding this, but he did not say R1 got up that night on 8.12.23. On 9.7.23 at 12:59pm V10 (Nurse) said he did not tell the facility that R1 got up during the night shift. V10 said he heard R1 whistle that night on two occasions. V10 said when R1 whistles he wants a brief change. V10 said maybe V9 told him that R1 got up, V10 then said it was weeks ago, he doesn't remember. V10 said the previous nurse did report to him that R1 had a fall that morning, and the doctor ordered an X-ray. On 9.7.23 V6 (Care plan/ Minimum Data Set Coordinator) said she updates the care plan for medical diagnosis and post fall interventions. V6 said she developed R1's fall risk care plan. V6 said R1 is at risk for fall due to muscle weakness, unsteady gait, Parkinson's, tremors, anxiety, and history of falls. V6 said the team discuss the fall and develop fall interventions together. V6 said the fall interventions would be based on the root cause of the fall. V6 said she do not determine	S9999		

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the root cause of the fall. R1 fall investigation conclusion reviewed with V6. V6 said the conclusion is that R1 frequently gets up on his own and ambulates a few steps with an unsteady gait. V6 said R1 getting up with an unsteady gait, with his diagnosis of dementia makes him at risk for falls. V6 said she don't know if the staff reported to her that R1 gets up frequently. V6 said she should have been made aware of R1 getting up frequently. V6 said she can't say what fall interventions would have been put in place because this is discussed with a team. V6 said an immediate intervention post R1 fall on 8.12.23 was to complete an Xray. R1 fall interventions reviewed with V6 which denotes placing R1 near to the nurse station when out of bed for supervision. V6 said this is so that staff can monitoring R1 because R1 will tray and self-transfer when sitting in his room at the bed side. Instruct resident in the proper use of any appliance or devices to aide in balance. V6 said R1 used a wheelchair, and staff is to ensure R1 is not leaning when sitting in the wheelchair. Instruct the resident to ask for assistance prior to attempting to transfer or walk. V6 said R1 should ask for assistance before trying to transfer or walk. V6 was asked if R1 had dementia and would he remember to ask for assistance. V6 was asked if R1 asked for assistance before getting up from bed on 8.12.23. V6 said she miss wrote that intervention, it should have read that staff should remind R1 to ask for assistance before trying to transfer or walk. V6 was asked if R1 would be able to remember to ask for assistance before getting up to transfer or walk. V6 then said maybe the facility could have put a sign up to tell R1 to use the call light before transferring or walking. V6 was asked if R1 would remember to read the sign before transferring or trying to get up. V6 was asked if

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the interventions be effective if R1 has dementia and may not be able to remember to ask for help before trying to transfer or walk. V6 said the interventions might not be effective. R1 fall risk assessment reviewed with V6 dated 6.28.23, denotes fall score of 2 (low risk). V6 said the fall risk assessment is not correct, it does not capture all the risk factors for R1. If the assessment was completed correctly the score would be 10 thereby placing R1 a risk for falls. V6 said balance problem while standing should have been checked (score1), confined to chair totally unable to ambulate without assist (score 3), and contributing factors (score 2) medications taken (score 2).

Review of R1's medication administration record dated 8.12.23, there is no documentation denoting that R1 received pain medication for the complaint of pain in the hip on 8.12.23.

On 9.7.23 at 9:44am V11 (Director of Nursing) said she V3 should have given R1 something for pain.

R1's pain assessment dated 8.12.23 at 12:23pm denotes in-part, indicators of pain- vocal complaints of pain (that hurts, ouch, stop). Received scheduled pain medication regimen "NO" is checked.

R1's physician order sheet with start date of 4.13.23 shows orders for acetaminophen tablet 500 mg (milligrams) one tablet orally every 8 hours PRN (as needed). Naproxen tablet 500 mg (milligrams) one tablet oral twice a day PRN (as needed).

R1's nurse's note dated 8.13.23 1:31pm states "Writer spoke with (Nurse Practitioner) about

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S9999	Continued From page 10 resident. Writer received orders to send patient out to (local hospital emergency room) for follow-up. Orders received and carried out." R1's emergency room record dated 8.13.23 denotes in part emergency room by ambulance from skilled nursing facility. Patient had a fall yesterday evening was really scheduled for an inhouse X-ray and assessment by physician there but apparently this never happened. Today the patient is less responsive than baseline and has acute pain over the left hip patient only able to respond to his name otherwise nonverbal during assessment. This is a 78-year-old male with past medical history of vascular dementia Lewy body dementia, Parkinson's disease, chronic bronchitis presenting to ED (emergency department) for hip pain phone and concerns for sepsis. Patient presenting on stretcher with left leg folded and crossed under self, painful to straighten patient shouting and grimacing when placed in anatomic position was shortened and externally rotated severe tenderness on the lateral compression of hip. ED diagnosis sepsis close displaced intertrochanteric fracture on left femur. R1 care plan for fall with problem start date 4/20/2023 denotes in-part one is a risk for falls related to muscle weakness unsteady gait diagnosis of Parkinson's tremors anxiety and history of falling. Goal-R1 will remain free from major fall related injury. X-ray per order. Place resident near the nurse's station when out of bed for supervision and monitoring and guidance. Instruct resident in the proper use of any appliances or devices to aid in balance. Instruct resident to ask for assistance prior to attempting to transfer or walk. Keep it in lowest position with brakes locked. Keep call light in reach at all times. Keep personal items and frequently used	S9999		

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S9999	Continued From page 11 items within reach. Observed frequently and place in supervised area when out of bed. Occupy resident with meaningful distractions. Orientate resident when there have been new furniture placement or other changes in environment. Provide one or more staff assist if resident has mood/ behavior, impaired mobility/ weakness pain or discomfort, restlessness and or agitation, provide well maintained footwear. R1's plan of care for pain denotes alteration on comfort secondary to pain related to osteoarthritis and intervertebral disc disorders thoracolumbar region. Goal R1 will express relief/decrease discomfort as evidence by verbalization of decrease or absence of pain, relaxed facial expression and body position. Interventions are to administrator medication as per order and observe for result. Facility policy titled Pain dated 11/22 denotes in-part it is the policy of this facility to school (sic) all residents for pain identify those who are experiencing pain and assess and develop effective individualized pain management care plan. Facility policy titled Falls prevention and management dated 3/2022 denotes in part the purpose of this policy is to support the prevention of falls by implementation of a preventive program that promotes the safety of residents based on care processes that represent the best ways we can currently know of preventing falls. The falls prevention and management program is designed to assist staff in providing individualized person centered care. The falls prevention and management program provide a framework and tools to identify and communicate about a resident risk of falls. Additionally, the program	S9999		

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GENERATIONS OAKTON PAVILLION	1660 OAKTON PLACE DES PLAINES, IL 60018

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S9999	Continued From page 12 addresses a safe process to follow supporting a resident who has experienced a fall event. Universal fall precautions- universal fall precautions are safety measures that are taken to reduce the chance of falls fall residents regardless of individual fall risk. Care planning and interventions to address fall risk factors- development of fall risk care plan is based on results of falls of assessment as well as investigation of all circumstances and related resident outcomes. The care plan addresses universal fall for cautions and universal fall risk as applies to the resident. A fall care plan will be implemented as part of the baseline care plan to address universal phone caution and it's part of the comprehensive care plan utilizing information from the fall risk assessment the care plan will be reviewed and revised at least quarterly and will any fall event the resident might experience. Post fall response-past history of a fall is the single best predictor of future falls. In fact, there's 30-40% of those residents who fall will so do it again. Thus, it is critical for staff to respond quickly and effectively after a fall. A post fall response includes immediate actions to ensure the safety of the resident assessment clinical review investigation and observations of the dictation of immediate action to prevent further falls notification of appropriate parties. "A"	S9999		