STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT REGENCY	6631 MILWAUKEE AVENUE NILES, IL 60714

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S 000	Initial Comments Complaint Investigation 2390783/IL155847	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6)	S9999		
	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. 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		**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to develop effective interventions to prevent or reduce the risk of falling for a resident with dementia, unsteady gait, poor safety awareness, and high risk for falls. This failure affected 1 of 3 residents (R2) reviewed for fall prevention. These failures resulted in R2 being involved in a fall incident casing pain to the left hip area. R2 was sent to the local hospital and evaluated and treated for a left hip fracture. Findings include: R2 face sheet shows R2 is 91-year-old female with diagnosis of dementia, anxiety disorder, psychosis, chronic kidney disease, hyperlipidemia, dysphagia, unsteadiness on feet, abnormal weight loss, altered mental status,	S9999		

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S9999	Continued From page 2 history of acute respiratory disease, hypertension. On 2/6/23 at 12:50PM V18 (R2 family) said she doesn't feel like the facility put adequate fall interventions in place for R2. V18 said R2 fell in November and sustained a hematoma and bruise to her head. V18 said V19 (Nurse) informed her that R2's bed alarm was not in place on 12/19/22 when R2 fell. V18 said she had questions why the nurse didn't hear R2's alarm sounding but instead heard R2 yelling for help. V18 said she voiced this concern with the facility and she (V18) was told that R2 fiddled with the alarm and it was not on. V18 said R2 fell in the dining room on 12/27 and she wonder how it happened. V18 said she has concerns about R2's falls at the facility. V18 said R2 sustained a hip fracture and had surgery and R2 has since passed away. V19 was called on 2/6/23, message text and voice mail left for V19. However, V19 did not return call to surveyor during this survey. R2 MDS dated 11/30/22 section C denotes 1 for short term memory problems, 1 for long term memory problems, cognitive skill for daily decisions making 3 for severely impaired. Inattention (difficulty focusing attention) is noted at 2 (behavior present, fluctuates). Disorganized thinking (rambling or irrelevant conversation, unclear or illogical ideas or unpredictable switching from subject to subject) 2 is noted 2 (behavior present, fluctuates). Section G for activities of daily living denotes R2 requires extensive assist and 1-person physical assist with bed mobility. Transfer shows R2 requires extensive assist and 1-person physical assist with transfers. R2 fall report dated 11/18/22 denotes in part, R2	S9999		

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S9999	Continued From page 3 observed on the floor post fall. R2 unable to verbalize what happened that led to fall d/t diagnosis of dementia. R2 is in temporary new environment d/t COVID-19 status and unable to acclimate easily to environment d/t dementia. R2 transferred to hospital for further medical evaluation. CT negative for major injury. R2 to continue skilled therapies, bed alarm provided at this time. On 2/5/23 at 11:20am V5 (Restorative nurse/ falls nurse) said R2's fall was due to R2 being in a new surrounding due to room being temporary changed. V5 said the intervention was to put a bed alarm in place. R2 fall report dated 12/19/22 denotes in-part fall, time 1:50am, resident room, sleeping or lying in bed, witness-none. R2 observed on the floor post fall. R2 observed sitting on the floor, arms on each side, legs positioned straight. R2 unable to verbalize what happened that led to fall. R2 is noted sitting on folding chair brought by family, chair observed folded. Chair removed from room. Family educated in regards extra furniture in. Family verbalized understanding. Fall precautions remain in place and working condition. Staff to continue to monitor and redirect R2 as needed. On 2/5/23 at 11:20 am V5 (restorative nurse/ falls nurse) said the intervention was to remove the clutter from R2 room (regarding 12/19/22 fall). V5 said she don't know what R2 was trying to do. V5 doesn't know why R2 was out of the bed at 1:50 am (on 12/19/22). R2 fall risk dated 12/19/22 denotes in-part R2 is high fall risk (score 15), has intermittent confusion, balance problems with walking, requires use of assistive devices, R2 is up adlib,	S9999		

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S9999	Continued From page 4 assistance to/from toilet, use antihypertensive, R2 had 1-2 falls in last 3 months, decline in functional status, referrals to fall program, continue current care plan. R2 fall investigation dated 12/27/22 denotes in-part, fall, dining room, ambulating, witness-none. Injuries- right eyebrow. R (right) forehead noted with raised discoloration area. R2 observed on the floor in dining room post fall. Per R2, she "wanted to get some water". Head to toe assessment done, no injuries sustained. R2 transferred to her room, fluids offered. R2 referred to NP post fall, referred to neurologist MD (Medical Doctor) D/T (due/to) increased falls. Fall precautions remain in place and in working conditions. Staff to continue to monitor and redirect R2 as needed. Recommendations- none noted. On 2/5/23 at 11:20am V5 (restorative nurse/ falls nurse) said the intervention was to refer R2 to the neurologist (regarding 12/27/22 fall). V5 said R2 had not seen the neurologist by date of discharge on 1/5/23. V5 said the water cooler was about 10 feet from R2 wheelchair. V5 was asked if the dining room floor was wet when R2 slipped and fell. V5 said she didn't know; she would have to ask the nurse that was on duty. V5 said she completed the investigation for this fall. V5 said she did not ask the nurse if the floor was wet when R2 fell. V5 said staff was in the dining room passing dinner trays. V5 was asked why staff in the dining room didn't redirect R2 immediately when R2 got up from the wheelchair. V5 respond that, "We do our best to monitor." V5 was asked if there were new interventions put in place after the fall on 12/27/22. V5 said the neuro consult. Review of R2 most current POS (physician order	S9999		

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S9999	Continued From page 5 sheet) there are no orders noted for a neurologist consult noted. R2 progress note dated 12/31/22 while passing medications in the dining room, writer heard sound of bed alarm coming from resident's room (R2's room), immediately went to resident's room accompanied by another RN. Walked into the resident's room, observed resident lying on the floor next to her bed on left lateral side. Un-witnessed fall, resident was immediately immobilized on the floor in order to perform head to toe assessment. Assessed resident for pain, patient denied any pain. Resident A/O x 1 on and off, confused in her base line mental status. DX: Unspecified dementia with behavioral disturbance. V/S checked BP: 151/73 P:98/MIN SPO2: 97% RA T: 98.2 F tympanic R:19/min. Writer asked the resident what happened, resident unable remember and verbalize due to dementia cognitive. Resident was asked if she hit her head, resident verbalized "No, I did not hit my head, only my left elbow". Resident denied any pain. Resident did not complain of any headache, nausea, or dizziness. Writer immediately performed head to toe assessment with another nurse, head, and neck intact, no redness, no discolorations or swelling observed. Writer observed small superficial skin tear on left elbow, no swelling, and no redness no S/S of infection at the area, first aid provided tolerated well. Resident is able to move her head and neck without any limitations or pain. Eyes checked: PERRLA. Resident is able to move her upper and lower extremities without any limitations, no Rotation/Deformity/Shortening noted. Hand Grasp: Equal in upper extremities. Neurological assessment initiated due to un-witnessed fall/ in resident's baseline. After the assessment resident was placed safely on her bed. Bed at lowest	S9999		

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S9999	Continued From page 6 position, call light within reach, bed alarm on all the time. Nursing supervisor/ POA/MD made aware. R2 fall investigation dated 12/31/22 denotes fall, activity- sitting, witness- none. Injuries none noted. Immediate action neuro checks initiated, placed in wheelchair, 1:1 supervision implemented, ROM (range of motion) W/I (within) normal limits for residents, POA notified of occurrence, resident care card updated, assess for pain, encourage resident to ask for assistance before standing, referred to PT, placed in bed, head to toe body check, notified immediate supervisor, CNA assigned updated, refer to other physician, neuro assessment, MD notified, refer to OT. Conclusion written by V5 (restorative nurse) entered on 2/4/23 at 12:34 pm R2 observed on the floor next to her bed post fall. R2 unable to verbalize to staff what happened that led to fall D/T Dx (diagnosis) of dementia. R2 denied pain or discomfort post fall. First aide provided to left elbow by NOD (nurse on duty). Staff to continue to remind R2 not ambulate/ transfer without staff assistance. R2 referred to skill therapies post fall. R2 has fall preventions measures in place and in working condition. Staff to continue to monitor and redirect. On 2/4/23 at 4:10 p.m. V7 said on 12/31/22 she was near the dining room when she heard a bed alarm and as she went to see where the alarm as coming from, she noticed R2 laying on the floor near her bed. V7 said R2 had an abrasion to the left elbow and first aid was rendered. V7 said she completed an assessment along with the other nurse. R2's range of motion to the upper and lower extremity was within normal range for R2. V7 said R2 denied pain and could not say what happen. V7 said she had just walked past R2	S9999		

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S9999	Continued From page 7 room and saw R2 sitting on her bed. V7 said her, another nurse and V6 all got R2 up and placed R2 in the wheelchair and escorted R2 to the dining room. V7 said R2 has dementia and has poor safety awareness. V7 omitted going into R2 room to determine if R2 needed something and or to determine why was R2 sitting at R2's bedside just prior to the fall. V7 was asked what R2's behavioral disturbance was. V7 said she did not know about R2 having a behavioral disturbance. On 2/5/23 at 11:20 am V5 (restorative nurse/ falls nurse) said the intervention was to give R2 verbal reminders not to ambulate without assistant. V5 said this is done if the staff sees R2 trying to get up from the bed. V5 was asked if the staff was doing that already. V5 responded, "I care planned that on 1/2/23." V5 said R2 was referred to physical therapy also. V5 was asked what was R2 trying to do when R2 fell. V5 said R2 could not say because R2 has dementia. V5 was asked if the nurse should have gone in to R2's room see if she needed anything when she saw R2 sitting at the bed side. V5 responded, "Yeah if she saw (R2) trying to get up, but she didn't know if R2 was trying to get up." V5 was asked if it's reasonable to believe that one must come to a sitting positing before getting up from bed, and that could be an indicator that a person may be trying to get up if they're sitting on the bed. V5 said R2 would usually sit in her chair at the bedside, so she would not think R2 was trying to get up from bed. V5 said she doesn't know what R2 was trying to do. V5 said R2 has dementia and poor safety awareness. V5 said R2's room is in a high traffic area so R2 can be monitored by staff as they walk pass or are sitting at the nurse station. V5 was asked how was R2 being monitored. V5 said staff should check on R2	S9999		

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S9999	Continued From page 8 frequently, redirect R2 if R2 is trying to get out of bed, toilet R2 as needed, provide water if R2 needed it. V5 said R2 was put on 1:1 monitoring after the fall on 12/31/22. V5 said she conducts the fall investigation at the facility and the root cause of the fall and interventions are developed with the interdisciplinary team. V5 said the facility does not have a fall prevention program. They use universal fall precautions. V5 said the fall interventions should be developed and implemented based on the root cause of the fall. V7 (Nurse) omitted putting R2 on 1 to 1 monitoring after the fall on 12/31/22. V7 said R2 was put in the wheelchair and taken to the dining room with the other residents. On 2/6/23 at 2:13pm V9 (ADON) said all falls should be thoroughly investigated. V9 said the falls are reviewed in the daily morning meetings. V9 said the falls interventions are developed with the interdisciplinary team. V9 said, "we" don't know what R2 was trying to before she was observed on the floor on 12/31/23. V9 said it is not uncommon for R2 to be sitting at the bedside because that's what R2 used to do before she started having falls. V9 said R2 had COVID-19 infection and was weaker. V9 was asked if R2 was weaker according to what she just said, would it be reasonable to believe R2 could fall if she is observed sitting at the bedside alone, has poor safety awareness, needs one-person physical assist with bed mobility, and recently had a fall from the bed and is a high fall risk. V9 said she would expect the nurse to go in R2 room if she saw R2 at sitting at the bedside to redirect R2. V9 said R2 needs one-person assist with bed mobility and transfer. Review of R2's current POS shows there were no	S9999		

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S9999	Continued From page 9 orders noted to limit R2's movement or keep R2 in the bed until R2 gets the left hip X-ray completed. V10 (CNA) said R2 was up in the wheel chair for her shift (3-11pm) on 1/4/23. R2 Xray dated 1/4/23 shows in-part R2 had the alignment is normal, acute left femoral neck fracture. The joint appears well maintained. The soft tissue is unremarkable. R2 progress note dated 1/5/23 denotes in-part on call Doctor called and ordered the patient to be sent to ER (emergency room) for evaluation.	S9999		
	On 2/5/23 at 11:20am V5 said that fall risk assessment is not accurate because R2 should not be up at liberty, R2 requires monitoring. V5 said the fall risk assessment should be completed accurately because that information is used to developed plan of care for fall intervention. R2 fall risk assessment dated 12/31/22 denotes a fall score of 22 (high risk). R2's care plan shows problem start date 2/3/2020. R2 is at risk for falling R/T poor safety awareness, d/t Dementia Dx (diagnosis), Anxiety, and Unsteadiness on feet. R2 is non-compliant with fall prevention measures. R2 will remain free from injury r/t (related to) fall target date 2/28/23. Xray of Left hip/femur/ thigh ordered d/t complaints of pain post fall. R2 referred to skilled therapies post fall. Give R2 verbal reminders not to ambulate/transfer without assistance. Neuro consult d/t recent falls. R2 referred to NP post fall. Provide R2 an environment free of clutter. Provide R2 with safety device/appliance: bed alarm. Transfer R2 to RMC ER for further medical evaluation post fall. Assure R2 wears proper well-maintained footwear. Assure floor is free of glare, liquids, foreign objects, encourage R2 to			

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S9999	Continued From page 10 assume a standing position slowly, encourage R2 to use environmental devices such as hand grips, handrails, keep call light in reach at all times, observe frequently and place in a high traffic area when out of bed, occupy R2 with meaningful distractions, provide R2 with an environment free of clutter, keep personal items and frequently used items within reach. Facility Fall Prevention and Management policy with revised date on 3/2022, denotes in part the purpose of this policy is to support the prevention of falls by implementation of preventive program that promotes the safety of resident based on care process that represents the best ways we currently know of preventing falls. The falls prevention and management program is designed to assist staff in providing individualize, 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 addresses a safe process to follow for supporting a resident who has experienced a fall event. Fall prevention and management practices includes separate activities. Universal fall precautions, standardized assessment of fall risk factors, care planning and interventions to address risk factors, post fall response including analysis of procedures and outcomes. Universal fall precautions are safety measures that are taken to reduce the chance of falls for all residents, regardless, of individual fall risk. The fall risk assessment is used to identify fall risk factors. Developing of fall risk care plan is based on results of the fall assessment as well as investigation of all circumstances and related resident outcomes. The care plan addresses universal fall precautions and individualize fall risk factors as applies to the resident. A fall care plan	S9999		

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S9999	Continued From page 11 will be implemented as part of the baseline care plan to address universal fall precautions and as 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 with any fall event the resident might experience. Alarms may be useful method of altering staff of a resident's movement which may pose a risk to their safety. Staff shall maintain communication with appropriate personnel when situations or resident behaviors suggest that the current interventions are not effective. The facility shall re-evaluate as needed to promote safety. Past history of a fall is the single best predictor of future falls. In fact, 30-40% of those residents who fall will do so again. This, it is critical for staff to respond quickly and effectively after a fall. A post fall response includes immediate actions to assure the safety of the resident, assessment/ clinical review, investigation and observation of the fall circumstance, implementation of immediate actions to prevent further falls, notification of appropriate parties. (A)	S9999		