Illinois Department of Public Health

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 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2398244/IL165090 Facility Reported Incident of 07/08/23/IL163175	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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: 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to have effective interventions in place to keep a resident free from fall related injury for a	S9999		

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S9999	Continued From page 2 resident with a history of falls. This failure applied to one (R6) of one resident reviewed for accidents and supervision and resulted in R6 experiencing four falls in four months and sustaining a laceration to the head requiring three staples and a subdural hematoma. Findings include: R6 is an 83-year-old male who has multiple diagnoses including but not limited to the following: difficulty in walking, altered mental status, need for assistance with personal care, muscle weakness, frontotemporal neurocognitive disorder, unsteadiness on feet, abnormalities of gait and mobility, failure to thrive, and dementia. Per fall report and progress notes for R6 dated 7/8/23, shows resident had an unwitnessed fall while ambulating in his room. R6 was noted to have a laceration to the back of the head and was sent to the hospital where he returned to the facility with three staples. Per fall report, no recommendations were made. Per plan of care, resident did receive a bed alarm that was later discontinued on 8/14/23 and reinstated on 9/8/23. Per fall report and progress notes for R6 dated 8/10/23, shows resident had a witnessed fall while ambulating in room. R6 was seen ambulating with shoes that were bigger than his feet. R6 fell backward in room and hit back of his head. R6's closet was assessed to ensure shoes fit, plan to ensure resident is wearing proper footwear, and roommate's shoes were moved out of reach. Per fall report and progress notes for R6 dated 9/25/23, shows resident had an unwitnessed fall and was found on the floor next to the bed.	S9999		

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S9999	Continued From page 3	S9999		

Interventions were to provide toileting assistance prior to going to bed and a medication review was completed.

Per fall report and progress noted for R6 dated 10/1/23, show resident had an unwitnessed fall while ambulating in his room. R6 was found in room behind door, laying on his left side with bed sheet wrapped around lower extremity. R6 was sent to the hospital where he sustained a subdural hematoma and was later admitted to inpatient hospice.

On 10/25/23 at 12:16PM, V6 (Licensed Practical Nurse) was interviewed regarding R6. V6 said I took care of R6 many times. R6 had dementia and got very confused later in the day. R6 was noncompliant with care and needed a lot of redirection. R6 would do things like put two legs in one leg pant, put items down his pants, rummage through his closet, etc. V6 said R6 was constantly getting up without asking for assistance. R6 had advanced dementia and could not use the call light. R6 needed one on one supervision but we do not provide this at the facility. V6 said, "We would try and have a staff member with him at all times, but that is not something we could sustain. His (R6's) room was not close to the nursing station but was closer to the dining room. I know he had falls but I do not remember specifics".

Per R6's fall reports, V6 was the nurse on 8/10/23 and 9/25/23, however V6 could not provide this surveyor with any details on the falls.

It is to be noted that resident (R6) resided in a room on the other side of the unit, not visible or in close proximity to the nursing station.

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S9999	Continued From page 4 On 10/23/23 at 12:19PM, V17 (Restorative Director) was interviewed regarding the fall prevention program within the facility. V17 said, "(V18 - Assistant Director of Nursing) and me are responsible to complete the fall reports. (V18) lets me know what interventions will be put in place and I add them to the reports and care plans. Some interventions that we utilize in the facility are low beds, floor mats, bolsters that are built in to the mattress, anti-slide wheelchair device, anti-roll back brakes, etc." On 10/25/23 at 10:45AM, V2 (Director of Nursing) was interviewed regarding R6. V2 said, "I am not familiar with his (R6) falls as I started here in August. I did know (R6) was confused, impulsive, and unaware of his safety". This surveyor requested names of staff members that could provide information regarding R6 and his falls. V2 directed this surveyor to interview V18 (Assistant Director of Nursing). At 11:45AM, this surveyor attempted to interview V18 regarding R6 and his falls. However, V18 said she was not familiar with R6 and could not provide much information about his falls. On 10/24/23, all fall reports for R6 from July 2023-October 2023 were requested from both V1 (Administrator) and V2 (Director of Nursing). Fall reports for 7/8/2023, 9/25/23, and 10/1/2023 were received. The fall list reported falls for R6 on 7/8/2023, 9/25/23, and 10/1/2023. Progress notes dated 8/10/23 showed R6 sustained a fall. Requested fall report for 8/10/23 from V1 and V2 on multiple occasions on 10/25/23. This surveyor was provided a document without R6's name present and brought concern up to V1. Later, this surveyor was given a fall report from 8/10/23. It is to be noted the fall on 8/10/23 was not listed on the fall list and was not initially given to this	S9999		

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S9999	Continued From page 5 surveyor with the requested documents. It is also to be noted that this surveyor received fall reports and care plans on 10/26/23, two days after they were requested that did not match the original documents received. It is also to be noted that some of the interventions listed on the original care plan received were not part of the new care plan received on 10/26/23. Facility policy titled Falls Prevention and Management with reviewed dated of 2/2023 states in part but not limited to the following: The purpose of this policy is to support the prevention of falls by implementation of a preventative program that promotes the safety of residents based on care processes that represent the best ways we currently know of preventing falls. Development of the fall risk care plan is based on results of the falls assessment as well as investigation of all circumstances and related resident outcomes. The care plan addresses universal fall precautions and individual fall risk factors as applies to the resident. Staff shall maintain communication with appropriate personnel when situations or residents behavior suggest that the current interventions are not effective. The facility shall re-evaluate as needed to promote safety. (A)	S9999		