| 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 10/13/2024 |

| 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<br><br>Complaint Investigation 2497728/IL178454 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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. | S9999 | | |

| 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 10/13/2024 |

| 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 |
|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

These requirements were not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to effectively supervise and ensure one resident was seated properly in wheelchair with feet on footrests or elevated off floor prior to transporting. This affected one of three residents' (R1) reviewed for safety. This failure resulted in R1 falling from the wheelchair sustaining a laceration to forehead requiring seven sutures and a left patella fracture.

Findings include:

On 10/12/24 from 11:20 AM until 12:40 PM R1 was observed sitting in wheelchair in the dining room. R1 was observed sitting with back against wheelchair back and holding a doll. R1 was able to feed self once her meal was set up for her. R1 was not observed shifting weight, leaning forward in wheelchair, or making any sudden movements.

On 10/12/24 at 12:40 PM, V3 CNA (certified nurse aide) was observed transporting R1 to R1's room. R1's room is directly across from the nurses' station. V3 and V4 CNA were observed transferring R1 from wheelchair to bed. R1's wheelchair was placed next to bed. V4 placed a gait belt around R1's waist and drag pivoted R1 onto her bed. R1's legs were bent at the knees throughout transfer. R1 was not able to straighten legs to support R1's weight. R1's upper body was observed leaning far forward. R1 was totally dependent on V3 and V4 for transfer.

R1's care plan, initiated 5/1/2015, notes R1 has risk or actual needs/symptoms related to

| 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 10/13/2024 |

| 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 |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

Alzheimer's disease and dementia. Interventions include provide reminders for ADL (activities of daily living) and provide cues and supervision for ADLs every day.

R1 falls care plan, initiated 5/1/2015, notes R1 is at high risk for falling related to decreased bed mobility and ambulation, Alzheimer's disease, dementia, muscle weakness, difficulty in walking, and multiple comorbidities.

R1's falls risk assessment, dated 7/16/24, notes R1 is at high risk for falls.

R1's OT (occupational therapy) evaluation, dated 6/25/24 notes R1 dependent for upper body dressing, transfers, and unable to stand and bear weight. R1's OT discharge summary, dated 7/25/24, notes R1 requires substantial/maximum assistance with upper body dressing. R1 requires substantial/maximum assistance with transfers from bed to wheelchair to bed. R1 is able to stand for 30 seconds with maximum assistance of two persons. R1 achieved maximum potential with OT and was discharged from skilled therapy.

R1's MDS (minimum data set), dated 7/16/24, notes R1 with functional limitation in range of motion in both upper extremities. R1's cognitive status for daily decision making is severely impaired.

R1's ADL care plan, initiated 8/6/2019, notes R1 is at risk for ADL decline related to generalized weakness and deconditioning. Interventions include transfers - R1 is dependent on staff for all transfers, use mechanical lift device for all transfers. Wheelchair - R1 requires substantial/maximum assistance for locomotion.

| 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 10/13/2024 |

| 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 |
|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

R1 may require two person assist in periods of lethargy, weakness.

On 10/12/24 at 12:40 PM, V3 CNA (certified nurse aide) stated prior to R1's fall, R1 was able to self-propel in wheelchair. V3 denied witnessing R1 lean forward in wheelchair or attempt to stand unassisted by staff.

On 10/12/24 at 12:45 PM, V4 CNA stated prior to R1's fall, R1 was able to self-propel in wheelchair. V4 denied witnessing R1 lean forward in wheelchair or attempt to stand unassisted by staff. V4 stated prior to fall R1 was able to take a few steps with staff assistance.

On 10/13/24 at 4:15 PM, V5 LPN (licensed practical nurse) stated on 8/17/24, V5 was in the resident room next door to R1's room. V5 stated when V5 exited room V5 observed R1 on the floor. V5 stated V6 CNA informed her R1 leaned forward and fell out of wheelchair. V5 stated R1 was able to stand while sitting in wheelchair but would sit right back down. V5 stated R1 was able to self-propel in wheelchair prior to the fall.

On 10/14/24 at 12:13 PM, V9 CNA stated she was working on 8/17/24 evening shift when R1 fell. V9 stated prior to the event she was sitting at nurses' station charting on computer. V9 stated R1 is a two person transfer and she instructed V6 to let her know when she was ready to have her assist with transferring R1 to bed. V9 stated V6 CNA stated, "okay R1 lets go". V9 stated she did not hear V6 call out to R1 after this. V9 stated no other words were spoken prior to the fall. V9 stated she then heard a boom and looked up to find R1 lying on the floor on side in a fetal position; R1's legs are semi contracted.

| 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 10/13/2024 |

| 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 |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

R1's medical record, dated 8/17/24 at 7:08pm, V5 LPN (licensed practical nurse) noted after eating dinner, R1 was being taken to bed by V6 CNA in wheelchair upon which R1 leaned forward in wheelchair and fell forward, face down to the floor. Upon assessment R1 received moderate sized abrasion to middle of forehead with moderate blood present. R1 remains alert, and verbal during occurrence. Neurological check initiated: no deficits noted. No indication of pain or discomfort. No vomiting or loss of consciousness observed. Pupils equal and reactive to light. Level of consciousness and range of motion to all four extremities at baseline. R1's vital signs stable. EMS (emergency medical services) 911 called and arrived within 5 minutes of occurrence. R1 transported to the hospital for further evaluation.

On 8/18, the emergency room nurse said R1 had CT (computerized tomography) scan of the head, cervical spine, facial bones, and all are negative. R1 received seven sutures to laceration on forehead.

On 8/22 at 11:00am, V7 LPN noted V7 was notified by therapy upon R1 assessment, R1 grimacing and pointing fingers to the left knee. Upon assessment V7 noted R1's left knee swollen, light redness, warm to touch, skin intact. On pain scale, R1's pain is 6 out of 10. Acetaminophen administered. V8 NP (nurse practitioner) informed with order to send R1 back to the hospital to repeat CT scan, radiology due to R1's recent fall.

On 8/22, V8 NP noted laceration of mid forehead with seven sutures, discoloration of right and left eyes, and discoloration of chin. Left knee redness and swelling, limited range of motion.

| 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 10/13/2024 |

| 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 |
|---|---|---|---|---|
| S9999 | Continued From page 5<br><br>8/22 at 3:56pm, R1 returned to facility with diagnosis of non-displaced transverse fracture of left patella- brace (knee immobilizer) applied in the emergency room with order to follow up with orthopedic surgeon.<br><br>This facility's investigation into R1's fall notes R1 is cognitively impaired, with memory and recall problems. R1 communicates primarily in Polish. Per V6 CNA, R1 looked tired, V6 went to R1, unlocked brakes on wheelchair and was preparing to wheel R1 to room when R1 suddenly leaned forward resulting in R1 falling from wheelchair.<br><br>V6 is no longer employed at this facility and was unable to be interviewed during this survey.<br><br>(B) | S9999 | | |