STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000467	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT APPLEWOOD	21020 KOSTNER AVENUE MATTESON, IL 60443

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S 000	Initial Comments Facility Reported Incident of 12.20.23/IL170260	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were NOT MET as evidenced by: Based on interviews and observations the facility failed to supervise an impulsive, confused resident, with unsteady gait from getting into bed with another resident. This affected two of three (R1, R2) residents reviewed for supervison/monitoring. This failure resulted in R1 screaming, crying, and feeling nervous after R2 climbed into her bed. A reasonable person would have been scared and terrified. Findings include:	S9999		

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R1's diagnosis includes but is not limited to Dementia, Anxiety, Adjustment Disorder with Mixed Anxiety, Weakness, History of Transient Ischemic Attack, and Osteoporosis.

R2's diagnosis includes but is not limited to Diabetes mellitus, Heart Failure, Vascular Dementia, and Major Depressive Disorder.

Progress notes dated 12/10/23 at 5:25AM state R1 was heard yelling for help and upon entering the room staff observed her roommate (R2) in her bed. Resident (R1) was observed gripping a butter knife but was not aiming it towards R2. R1 unsure why R2 was in her bed.

On 4/6/24 at 12:16PM V3, Certified Nursing Assistant (CNA), said when she walked past the room she saw one resident on the floor and one resident on the bed. V3 said R1 was crying. V3 said R2 had a behavior of crawling on the floor.

On 4/6/24 at 12:29PM V5, CNA, said in general R2 was "very aggressive" she needed redirection and sometimes staff would stay with R2. V5 said R2 would get out of bed and she could walk a few steps. V5 said R2 would sometimes hit staff. V5 said if R2 was in a bad mood she would start hitting. V5 said R2 would "sundown" and show these behaviors more in the evening time. V5 said we had to check on R2 often. V5 said R2 was alert and confused at times, she fluctuated. V5 said R1 is cooperative, keeps to herself and is not like her to be aggressive.

On 4/6/24 at 12:43PM V1, Licensed Practical Nurse (LPN), said on 12/10/23 I was informed that the CNA saw R2 in R1's bed. V1 said I was told R2 was near R1's bed. V1 said I was told R2 was hovering over R1. V1 said R2 is not fully

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oriented. V1 said the CNA tried to redirect R2 to her bed. V1 said R1 was confused and I was told she had a butter knife that she grabbed from under the bed sheet. V1 said this happened around 6:00am. V1 said when I walked in the room I saw R1 in the bed and R2 was on the floor, scooting around the bed. V1 said R1 is alert times 2- 3. V1 said R1 said she did not feel comfortable with R2 in the room. V1 said R1 gave me the butter knife, it was a facility butter knife. V1 said this is new behavior for R1. V1 said I was not told there was anything going on with R1. V1 said R2's baseline is always moving around. V1 said R2 was someone who needed frequent checking on. V1 said V2, CNA, was the first staff in the room.

On 4/6/24 V2, LPN, was the CNA (was still CNA in December) assigned to R1 and R2 on 12/10/23. V2 said on night shift, I heard yelling and screaming, I immediately went into the room. R1 was calling out "help" repeatedly. V2 said I was in the room across changing a resident. V2 said when I got there I saw R2 on top of R1, in R1's bed. V2 said R1 was laying flat facing up and R2 was laying flat on R1 facing her. V2 said R1 had the butter knife. V2 said I don't know where R1 got it from. V2 said R1 and R2 had been rounded and changed. V2 said I had checked on R1 and R2 2 or 3 times before this. V2 said I don't know how R1 got in R2's bed. V2 said usually R2 can walk, but her balance is not steady. V2 said neither was awake on last round. V2 said I checked and changed them and they woke up. V2 said I was in the other room about 15 minutes. V2 said I asked R2 what she was doing and R2 was just confused and had no answer. V2 said R1 was nervous afterwards. V2 said R2 had slept most of the shift and it was unusual that she sleep the entire night. V2 said I

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did not see R2 crawling around the floor. V2 said R1 is not capable of getting out of bed, she does not get up on her own.

On 4/6/24 at 1:50PM V8, CNA, said usually R2 could walk but unsteady. V8 said we watched her often, I would keep her near us. V8 said R2 just wanted to get up and walk, she could not sit. V8 said R2 could not retain information. V8 said R2 would get in other residents' face and curse them out. V8 said R2 was verbally aggressive and physically aggressive with staff. V8 said we would move R2 to keep others safe. V8 said in the past, R1 said R2 would get into her bed or get into her belongings. V8 said R2 would be on R1's side of the room. V8 said they were not roommates for long. V8 said R1 didn't like that R2 was in her things.

On 4/6/24 at 2:24PM V9, Social Service Director, said I was not notified that R1 and R2 were not getting along. I was not made aware that R2 was rummaging in R1's things or on R1's side of the room.

On 4/6/24 at 2:45PM V4, Director of Nursing, said R2 has been confused since admission. V4 said she was not aware that R2 was verbal or physically aggressive to staff or residents. V4 said I was not told R1 was upset that R2 was on her side of the room and in her things. We would have spoken to R1 and investigated. At 3:31PM V4 said Vulnerable is anyone who could be taken advantage of or manipulated. The surveyor asked V4 can an aggressive person take advantage of a vulnerable resident, V4 said "sure". V4 said per the nurse practitioner note R2 was impulsive and refused to answer her questions. V4 said staff documented R2 was impulsive and hard to redirect from safety awareness. The surveyor

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S9999	Continued From page 4 reviewed R2's progress notes from 10/5/23; 11/4/23 aggressive behavior; 11/7 combative & aggressive with staff; 11/16 verbal aggression; and 12/7 refused medication with V4. V4 said I was not aware of those behaviors. V4 said R2 saw the psych nurse practitioner three times during that time. V4 said the nurse practitioner is not here every day. R2's Progress Notes dated 10/5/24 shows R2 requires 1 on 1 supervision, very impulsive behaviors. R2's care plan dated 12/15/23 states R2 exhibits abnormal behavioral symptoms, choosing to crawl on the floor at times. Interventions include seat R2 where constant/near constant observation is possible. Care plan dated 11/9/23 R2 exhibits verbally/physically aggressive behaviors towards staff. Care plan dated 9/26/23 states R2 exhibited decline in her status and exhibited lack of safety awareness. R2 exhibits impaired cognitive function due to diagnosis of Vascular Dementia with a BIMS score of 4. R1 care plan dated 12/27/23 states R1 has impaired vision and cognitive decline. (B)	S9999		