STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006837	A. BUILDING: _____ B. WING _____	C 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS OAKTON PAVILLION	1660 OAKTON PLACE DES PLAINES, IL 60018

(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 Investigation of Facility Reported Incident of November 20, 2023/IL169938 Investigation of Facility Reported Incident of December 12, 2023/IL169940	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.1210b)5) 300.1210d)6) 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 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: 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		

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This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to supervise a high risk for falls resident (R2) in a sample of 5 residents. This failure resulted in R2 sitting in a wheelchair at the nurse's station, falling asleep and leaning forward and falling out of his wheelchair to the ground face down. R2 sustained small laceration to bridge of nose, required hospital evaluation and required two sutures to the nose.

Findings include:

Facility's reportable to state agency regarding R2 documents in part: Date of Occurrence (11/20/23), R2 was sitting in a wheelchair at nurse's station and fell asleep, leaned forward, and fell from the wheelchair. R2 was evaluated by the nurse on duty to have active ROM x 4 with c/o (complaint of) pain to head and noted small laceration to the bridge of R2's nose. NOD (Nurse on Duty) provided first aid. R2 was transferred to hospital as a witnessed fall. While at the hospital, received two sutures to the bridge of nose and returned. Interviews: V8 (Certified Nursing Assistant/CNA) states R2 had been up at nurse's station. V8 was in hallway throwing his trash away when he heard R2 fell. R2 was sitting at nurse's station in his wheelchair and fell forward onto the floor face forward. V10 (Licensed Practical Nurse/LPN) went to his side. V9 (CNA) states R2 was trying to get out of bed, so I got him out of bed. I got him up between 5:30 and 6:00 am. I was bringing R2 from room to room with me. I

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went to help another resident in the dining room, R2 was at nurse's station in his wheelchair. He fell asleep and fell forward out of the wheelchair onto the floor. V10 went to his side to provide care.

V17 (CNA) states I was in hallway and heard a noise went to see what it was and seen R2 on floor in front of his wheelchair. I noticed he was bleeding from his nose. V10 went to his side and looked at him. V10 (LPN) states R2 was at nurse's station in his wheelchair when he fell asleep and fell forward from wheelchair to the floor. Noted that he was bleeding from nose. I provided first aid and did neuro checks. I called MD (medical doctor) and received order to send to hospital for further evaluation. 911 was called and care was transferred.
Conclusion: R2 was evaluated at hospital and returned with 2 sutures to bridge of his nose. Wound care to be provided until wound is closed. R2 fell asleep while in wheelchair and fell forward to the floor. R2's plan of care was updated, and intervention placed to return to bed when tired. (R2's reportable does not document R2 was seen falling by staff.)

R2's diagnoses includes Orthostatic Hypotension, Major Depressive disorder, Coronary artery disease, Atrial fibrillation, COPD, Tremors, Spinal Stenosis and Mild Cogitative Disorder. BIMs score dated 4/3/24 - 00 (indicating severe impairment)

On 5/17/24 at 11:32 am, R2 was observed. R2 did not remember the incident of 11/20/23.

On 5/17/24 at 11:36 am V7 (Registered Nurse/RN) said R2 is high risk for falls and when he ambulates, he needs to be 1 person assist, he

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gets up and walks and will fall if he walks by himself. V7 said someone needs to be visually supervising him because sometimes he will want to get up by himself and he will fall. V7 said, she would not leave the resident by himself at a nurse's station without watching him.

On 5/17/2024 at 12:33 pm V2 (Director of Nursing) was asked how R2's final report to state agency was documented as a witnessed fall, who witnessed the resident fall? V2 said, she thought it was V9 (CNA).

On 5/17/24 at 1:56 pm V9 (CNA) said, on 11/20/23 she was assigned as CNA for R2. V9 said as far as she remembers he was trying to get out of bed, and she did not want to leave him, and she got him dressed and took him with her on her rounds. V9 said she was rounding on her residents and would wheel R2 in a wheelchair with her and she left him outside the door and gave him crackers and cookies. V9 said once she was done rounding, she had to do ADL care (incontinence care) and the nurse (V10) was done with passing medications, and the nurse was at the nurse's station, so she left R2 with V10. V9 said she left and went to the dining room as another resident looked like she will fall and wanted to reposition her. V9 said while she was in the dining room, she heard a loud sound, and she went back to R2, and he was on the floor. V9 said maybe R2 dosed off and the nurse was there as she was sitting by the nurse's station. V9 said, she did not leave R2 alone. She (V9) left him with V10. V9 said R2 has history of falls, and she did not want to leave him alone in bed and she did not want him to fall, sometimes he wakes up at night and he insists on getting up and sometimes he keeps on trying to walk. V9 said when R2 is trying to get out of bed, as much as possible she

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will ask if he needs anything and will turn on the television and will give him a snack. V9 said that day she was taking R2 with her to prevent a fall. V9 said sometimes he gets confused with time and will say he wants to go home to his wife and is confused that he doesn't belong in the nursing home. V9 said she did not see R2 fall, she just heard a loud sound.

On 5/17/2024 at 2:21 pm V10 (RN) said on 11/20/23 she was the night nurse for R2. V10 said it was close to around 5:00 am R2 was trying to get out the bed. The CNA (V9) assisted, and we made rounds and rotated on and off watching R2. R2 was at the edge of the nursing station, it was the end of the shift. V9 went to check on another patient in the dining room. I (V10) was at the nurse's station at the other end and I turned and asked V8 (CNA) a question and then all we heard was boom. As soon as we (V8 and V10) turned around R2 was on the floor, he was face down with a cut on his nose. Day shift was coming in and assisted me (V10). I (V10) did not see R2 fall, I heard R2 and turned around. I (V10) believe V9 saw him fall but she (V9) was in the dining room and could not get to him in time. V9 was in the dining room, and I was at the nurse's station tidying up, you know finishing my charting and things. R2 had been attempting to get up the shift and I (V10) was talking to R2 then I started talking to other staff. We had R2 at the nurse's station so we could keep an eye on him (R2) at the nurses station.

On 5/18/24 at 9:19 am V2 (Director of Nursing) said regarding R2 he had history of insomnia and was getting up on his own and sliding off the bed, history of sliding from the bed, when he got up this day the CNA on duty and got him up and was watching him, and then she brought him to the

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nurse's station, and went to the dining room to attend to another resident, he was in her view with the nurse at the nurses station. V2 was asked how R2 managed to fall asleep and fall if he was watched by staff. V2 said it just happened fast. V2 said both V9 (CNA) and V10 said they saw R2 fall. V2 was asked why the resident fell in that case if he was being watched by the staff. V2 said it happened because they were not close enough to R2 to prevent the fall, they were not able to get to him in time. V2 said the nurse was by him, and she was on the other side of the desk. (R2 was able to fall asleep and lean forward and fall to the ground, staff on duty was not able prevent R2's fall.) Surveyor asked V2 how R2 managed to fall asleep and lean forward and hit the floor. V2 said, it just happened. V2 provided R2's fall history, R2 had 12 falls prior to the incident of 11/20/23.

On 5/18/24 at 9:51 am, V11 (Restorative Director) and V2 were present. V2 said R2 came to the facility because he had numerous falls at home and wife was unable to get him off the floor. V11 said when he was at home the wife was providing care alone. V2 said he had multiple falls at home prior to coming here, one of the falls resulted in subdual hematoma. V2 said V17 (R2's wife) had difficult time with getting him up and she started to do activities on the floor like she placed things in front of him, like books, watch television on the floor. V2 said the falls became too much to handle and that's why he came to the facility, he was referral from Veteran Administration. V2 said facility knew he was a fall risk prior to the resident coming here, he has insomnia and post-traumatic stress disorder, is followed by psychologist and neurology. V2 said R2 is showing aggression towards staff and seeks his wife. V2 said R2 has history of anxiety and has had behaviors towards

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his V17 (R2's wife). V11 had last fall on 4/17/24. V11 said, R2 has a fall care plan with interventions. V11 said after each fall, the facility adds interventions, and some are already discontinued. V11 provided a list of R2's discontinued fall interventions.

On 5/18/24 at 11:30 am V2 said the facility does not have policy on monitoring residents, policy on high fall risk residents. V2 said supervision of residents is embedded in everything the facility does and they do not have a written policy on supervision.

R2's (Start Date 07/11/2023) care plan documents in part: Resident is at risk for falls related to muscle weakness, impaired cognition, and history of falling and diagnosis of tremors, dementia, anxiety, visual impairment and psychotropic medication, poor safety awareness and spontaneous. Approach (Start Date 7/11/2023): Provide 1 or more staff assistance. If resident has mood/behavior; impaired mobility/weakness, pain, or discomfort; restlessness and or agitation. Approach (Start Date 3/09/2024): Resident is impulsive and due to diagnosis of cognitive impairment resident doesn't remember not to get up without assistance. Staff have exhausted all interventions. Will continue with care plan and monitor resident frequently.

R2's (11/3/23) "Fall Risk Assessment" documents in part: score of 20, high risk for falls.

Facility's "Assessment Tool" (7/22 through 6/23) documents in part:
Services and care we offer based on our residents' needs: Provide person centered/directed care: identify hazards and risks

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for residents.

The facility's Fall Prevention and Management Policy revised on 12/23 shows, "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.

On 5/17/2024 at 3:20pm surveyor asked V8 (CNA) if he remembered the fall incident R2 had in November 2023. V8 stated yes, I worked 11pm-7am shift. I remember but I do not remember the date, but I know he fell one time. I made a statement. I was in the other room and had trash to empty and linen to dump and as I was walking down the hall, I heard a boom; I was in the hallway. I last saw R2 in the chair because we were watching him. We were all watching him because he is a fall risk guy. He tries to get out of the bed most of the time. The nurse was done passing meds because he was with her then it was almost the end of the shift. I saw him face down on the floor, I tried to get a pillow and ice I don't know but the nurse wanted me to get ice and a pillow. He was at the nursing station because the nurse was with him, we want to keep an eye on him so everyone can see him. I was far from him. I did not see him fall I just heard the boom.

On 5/18/2024 at 11:34am surveyor observed residents in 4th floor dining room and without any staff in dining room monitoring residents. Residents sitting in wheelchairs and some in highbacked chairs, groomed and wearing shoes or non-skid socks.

On 5/18/2024 at 11:36am surveyor walked to

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entrance of dining room of 4th floor dining room and spoke to V15 (Activity Aide) and asked what her role was. V15 stated I just finished doing an activity with the residents and sometimes I will pass out coffee and put on bibs. Surveyor observed V15 outside of dining room pouring coffee then passing out to residents.

On 5/18/2024 Surveyor continued to observe residents in the dining room without supervision.

On 5/18/2024 at 11:38am surveyor observed nurses sitting at the nurse's station. No staff in residents dining room.

On 5/18/2024 at 11:42am V16 (LPN) stated all residents on this floor (4th) have dementia/Alzheimer and are confused. We have 2 activity aides; CNAs and we monitor residents. Surveyor asked V16 if residents had to be monitored when in the dining room. V16 stated, yes for safety reasons.

On 5/18/2024 at 11:46am surveyor standing in resident dining room observing residents with no supervision. V14 (CNA) entered dining room and took a seat. Surveyor asked V14 if anyone was in the dining room when she walked in. V14 stated, "No, when I came in here no one was in here. V14 stated, the nurses can see the residents when they are at the medication cart. Surveyor asked V14 were the nurses standing at the medication cart when you entered the room. V14 stated, "No." Surveyor observed both nurses at the nurse's station. V14 further stated, someone has to monitor the residents because they can choke, fall or hurt themselves.

"B"

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Statement of Licensure Violations II of II:
300.610a)
300.3210t)

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 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to keep a resident (R4) free from abuse in a sample of 5 residents. This failure resulted in R3 punching R4 in the face which caused R4 discoloration to the right eye and bleeding from nose and mouth.

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S9999	Continued From page 10 Findings include: Facility's reportable to state agency regarding R3 and R4 documents in part: On 12/12/2023 Nurse on duty, (V5) reported to Administrator R3 allegedly punched R4. Upon assessment, some discoloration was noted to his right eye and bleeding out of his nostrils and mouth. R4 was transferred to the hospital for further medical evaluation. R3 was transferred to the hospital as well for psychiatric evaluation. Police notified. R3's diagnosis includes Chronic obstructive pulmonary disease, unspecified, Anemia in other chronic diseases classified elsewhere, Schizoaffective disorder, depressive type, Amyotrophic lateral sclerosis, Thrombocytopenia, unspecified, Essential (primary) hypertension, Osteoarthritis of knee, unspecified, Hypothyroidism, unspecified, Anxiety disorder, unspecified, Insomnia. R3's care plan documents in part: resident is at risk of abuse due to schizophrenia diagnosis and history of provoking others. R4's diagnosis includes Malignant neoplasm of unspecified part of unspecified bronchus or lung, Dysphagia, unspecified, Benign prostatic hyperplasia with lower urinary tract symptoms, Muscle weakness (generalized), Major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, Insomnia, unspecified, Essential (primary) hypertension, Unspecified dementia, unspecified severity, with other behavioral disturbance. R4's care plan documents in part: resident is at risk for abuse for diagnosis of dementia and new alleged behavior of saying derogatory and	S9999		

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disrespectful comments, problem start date 3/1/23.
R4's care plan documents in part: R4 presents with agitation, compulsive behavior, excitability related to diagnosis of anxiety.

On 5/17/24 at 10:43 am V4 (Certified Nursing Assistant/CNA) said regarding R3 and R4, the incident happened last year in December. V4 said he recalls the incident, he worked 3 pm to 11 pm shift. V4 said it was around dinner time, he was passing trays to residents who eat in the rooms. V4 said he passed all trays and was assisting other residents and when he was done feeding another resident, he went to R4's room to feed him. V4 said when he walked in, R4 was bleeding from left side, from the nose, and he immediately called the nurse and they both came in. V4 said, R3 admitted that he punched R4. V4 immediately took R3 for safety and he was with him in the nurse's station most of the time until the police came.

On 5/17/24 at 12:35 pm V1 (Administrator) said regarding R3 and R4. V1 said it was reported of the incident that around 7 pm by the nurse that R3 punched R4. V1 said she went upstairs and saw R3 being watched by V4. They were by the nurse's station, ambulance came, and police came, both residents went out to the hospital. V1 said she went to R4's room and he had blood on his face and shirt was soiled with food, and paramedics were there, he said he was ok, R4 stopped responding to questions. V1 left and went with police to talk to R3 at the nurse's station and R3 said he hit R4 and was asked how and he demonstrated a closed hand. V1 said when asked why he hit R4, R3 said because R4 was coughing too much and when he asked R4 to stop coughing, R4 coughed again and R3 felt

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(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
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he was doing that on purpose. R3 said R4 responded by calling R3 a "filthy Jew". V1 asked police on guidance, and because they are both elderly and both had mental diagnosis the police would not pursue criminal charges and R3 was sent to hospital. V1 said facility discharged R3 and R3 did not want to come back to the facility. V1 said R3 never got in an argument with another resident but would get in arguments with staff. R3 was on fluid restriction and if he would ask for water, he would raise his voice and would ask for the water. V1 said she spoke to wife of R4, and she never saw any disagreements, but R3 was never too friendly. V1 said the result of the investigation was that the incident did happen and R3 hit R4 and R3 admitted that he hit R4.

R4's (12/12/2023 at 10:16 PM) progress note documents in part: At 5:50 pm writer called to room by CNA for a disruption, walking in the room found resident laying in his bed covered in food, noted skin discoloration, and swelling to right eye and nose bleeding from both nostrils. Roommate resident immediately separated.

R4's progress note (12/12/2023 at 11:10 PM) documents in part: hospital called to inquire about patient. Writer informed by NOD (nurse on duty) that patient was admitted to hospital with diagnosis of Trauma of face, head, and mouth.

Facility's "Abuse Prevention Guidance" (rev. 10/22) policy documents in part: this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property.

No Violation Issued