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GENERATIONS AT APPLEWOOD	21020 KOSTNER AVENUE MATTESON, IL 60443

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S 000	Initial Comments Facility Reported Incident Investigation. FRI of 8/13/22 IL150998	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210 a) 300.1210 b) 300.1210 c) 300.1210d)6) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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	S9999		

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on observations, interviews, and records reviewed the facility failed to assist a dependent resident back to bed, failed to ensure to provide assistance to a resident with impaired balance, failed to ensure fall prevention interventions were implemented and a fall risk assessment was completed per policy and procedures. These failures affected 3 of 3 residents (R1-R3) reviewed for fall preventions. This failure resulted in R1 falling asleep in the wheelchair and falling to the floor and sustaining a laceration with suture repair. Finding include: A. R1 is 73 years old with diagnosis including, but not limited to Epilepsy, Diabetes mellitus, Chronic Atrial Fibrillation, Peripheral Vascular Disease, and Hemiplegia and Hemiparesis following Cerebral Vascular Infarction affecting Left Dominant Side. R1 sustained a fall on 8/13/22. According to his cognitive assessment, R1 is noted to be cognitively intact. On 9/16/22 at 10:10AM R1 observed in bed. No star on R1's doorway. R1 noted alert. R1 said when I fell, I was sitting here in my chair. R1 indicated to center of the room, between the beds. R1 said I was watching TV and fell asleep. R1 said I had a knot on my head pointed to top of his left temple, along hairline. R1 said they gave me stitches. On 9/16/22 at 11:49AM R1 observed in bed, top half leaning to right side, head of bed elevated,	S9999		

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call light and sheet on the floor. R1 is not able to reach his light for assistance. R1 said his wheelchair is in the bathroom. The surveyor observed a seat
cushion in place, but no nonslip device placed on or under the cushion.

On 9/16/22 at 12:12PM V4, CNA, said a star on the door or a light bulb means to check the resident when walking by. V4 said all residents who use a wheelchair cushion should have a grippy device on the cushion. V4 said safety interventions are listed on the sheet in the resident closets. V4 presented R1's closet list that includes his transfer status, but no fall risk or safety interventions are listed on the sheet. V4 said, if the interventions are new they may not be on the list yet. V4 said she is not aware that R1 has fallen. R1's call light remains on the floor while the surveyor and V4 discussing the care sheet and fall interventions. V4 left the room and did not place R1's call light in his reach.

On 9/16/22 at 12:44PM, during a phone interview, V5, CNA, said on 8/13/22 she was assigned to R1. V5 said she had asked R1 if he was ready for bed, and he said no. V5 said she left R1 sitting in his wheelchair with the bedside table in front of him. V5 said about 45 minutes later R1 was seen on the floor. V5 said there was blood on R1's face and the floor. V5 said she thought R1 may have fallen asleep in his wheelchair and fell. V5 said she had not known R1 to have fallen before. V5 said residents at risk for falls have stars on their door.

On 9/16/22 at 2:36PM V11, Restorative Nurse, said regarding R1's fall on 8/13/22, I know R3, and he was ready to get back to bed. V11 said R1 had told the nurse working that he fell asleep in

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the chair. V11 said when I spoke to him, he said he was trying to get back in the bed. V11 said I know R1, he was ready to get back to bed. V11 said it was unusual for R1 to be out of bed at that time on the day of the fall. V11 said the papers in the closet doors show the residents' transfer status, but do not include safety interventions.

On 9/20/22 at 9:45AM V12, MDS Nurse, was asked if the care plan reads call light in reach, should it be in reach? V12 said yes. The surveyor asked what is the purpose of having the light in reach? V12 said so the patient can call for assistance, if they need to use the bathroom or reach for an item not in reach. V12 said whatever they need they can use the call light to ask for assistance.

Fall Record provided by the facility dated 8/13/22 initiated by V17, Agency Nurse, notes a fall occurred at 7:35PM with a laceration and hematoma to the left forehead. V17's phone number was requested, but not provided. The report notes R1 was observed lying prone next to wheelchair. R1 stated he fell asleep in his chair and fell. The conclusion written by V11 states R1 attempted to self transfer from the wheelchair to bed without staff assistance.

Review of R1's progress notes dated 8/13/22 note R1 was transferred to the hospital following his fall for evaluation. Progress note dated 8/14/22 note R1 returned to the facility with 1 suture to his scalp. Progress notes dated 8/22/22 note 2 sutures were removed.

R1's Fall Risk Assessment dated 6/30/22 notes R1 has intermittent confusion and is a High Risk for falls. The facility provided 2 fall risk assessments for R1 dated 10/25/21 and 6/30/22.

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S9999	Continued From page 5 No fall risk assessment provided following fall on 8/13/22. R1's hospital record dated 8/13/22 notes a 4 x 3 x 2 cm left parietal hematoma with abrasion. Additionally, Frontal scalp contusion. Assessment notes scalp hematoma and underlying laceration. Laceration repair performed with 1 suture to the left parietal region. Review of R1's Orders do not include fall prevention orders. R1's Cognitive Patterns Assessment dated 7/15/22 notes a score of 14, intact. R1's Functional Assessment dated 7/15/22 notes he required extensive assistance with bed mobility and transfers of 2 persons. R1's Fall care plan start date 10/25/21 note R1 is at risk for falling related to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side and unsteadiness on feet. Interventions include, start date 7/11/22, provide with safety device to wheelchair to prevent sliding; start date 10/25/21 keep call light in reach at all times. Risk factors on care plan do not include the contributing factors listed on the fall risk assessment, intermittent confusion, and medications. B. R2 is 84 years old with diagnosis including, but not limited to Dementia and Glaucoma. On 9/16/22 at 10:17AM, the surveyor observed R2 walking independently in the room from reclining chair into the bathroom. V14, Staffing Coordinator, walked past while he was up and walking and V14 did not intervene. No staff is	S9999		

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S9999	Continued From page 6 present in the room. No star or light bulb symbol outside of R2's door. On 9/16/22 at 10:27AM R2 observed to walk out of his bathroom and ambulate in the room. V1, Certified Nursing Assistant (CNA), walked past and did not stop to intervene. V1 interviewed outside of R2's room where R2 is visible. V1 said she is checking on people at least every 2 hours and when walking by for safety. V1 said when I check people I am looking to see if they need to use the bathroom, they have what they need, call lights in reach, water in reach, and that everything is in reach. These things need to be in reach, so the residents don't fall trying to get to them. No staff in R2's room as he continues to walk in his room. On 9/16/22 at 10:34AM, the surveyor observed R2 kneeling on the floor between the bed and recliner chair on his knees looking for something behind the recliner chair. On 9/16/22 at 2:04PM V9, CNA, said R2 can participate in cares. V9 said R2 is not independent, he can feed himself, needs help with dressing, and he can toilet himself. V9 said R2 would not change his clothes. V9 said R2 needs direction from staff. V9 said R2 can ambulate independently, he comes out for meals. V9 said stars or wrist bands are used to identify fall risk. On 9/20/22 at 9:45AM V12, MDS Nurse, was asked if a resident care plan states give resident verbal reminders not to ambulate/transfer without assistance, should they be ambulating or transferring independently? V12 said no, they should not walk independently. V12 was asked if this intervention is specific to the room or	S9999		

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S9999	Continued From page 7 anywhere? V12 said the intervention applies in general. R2's Fall Risk Assessment dated 5/18/22 notes R2 has balance problems while standing and walking. On 9/16/22 the surveyor requested a copy of R2's Fall Risk Assessment. The assessment dated 5/18/22 was provided. [This greater than 100 days since last assessed for fall risk.] R2's care plan start date 5/25/22 notes R2 experiences wandering (moves with no rational purpose, seemingly oblivious to needs to or safety). Start date 5/17/22 notes R2 is at risk for falling related to unspecified Dementia. Interventions include give verbal reminders not to ambulate/transfer without assistance. Place in fall prevention program. R2's cognitive Pattern Assessment dated 9/5/22 notes a score of 2, severely impaired. C. R3 is 86 years old with diagnosis including but not limited to Polyarthritis, Presence of Artificial Knee Joint, and Chronic Obstructive Pulmonary Disease. R3 was admitted to the facility on 9/10/22. On 9/16/22 at 11:35AM the surveyor observed R3 in her room at the end of the hallway, last room from the nurses' station. R3 sleeping in the side chair, door open to her room. R3 did not verbally respond to the surveyor. No star observed on the resident doorway. On 9/16/22 at 11:59AM V3, CNA, said residents at risk for falls are identified by the care plan posted in each residents' closet. V3 accompanied the surveyor to show the care plan. V3 showed	S9999		

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the surveyor a document posted in a random resident closet Transfer Sheet. V3 said this sheet will include the resident transfer status and if they are in the fall program. V3 said there is also a binder with safety interventions at the desk. V3 did not present the surveyor with a binder when asked. Transfer sheet reviewed and there is no safety intervention listed on sheet.

On 9/16/22 at 1:05PM V7, Registered Nurse, said on 9/15/22 the CNAs got R3 up in the morning, because she has a history of falling and R3 was sitting in her wheelchair at the nurse's station. V7 said I was in another resident's room and when I came out, I saw R3 on the floor. V7 said R3 fell in front of the nurses' station. V7 said R3 said she was trying to get to the phone. V7 said no staff was with her when R3 fell, but they heard her fall, and they came out of the rooms. V7 said any resident sitting at the nurse's station is a fall risk and are there to be watched. V7 said we might have an icon, but I am not 100% sure, to identify residents at risk for falls. V7 said fall prevention interventions are on the care plans and some are orders.

On 9/16/22 at 1:32PM V6, CNA, said he was assigned to R3 on the evening shift of 9/14/22. V6 said R3 sat with me most of the day yesterday because she was active. V6 said R3 was trying to walk, and she had said she didn't want to be alone. V6 said after dinner, R3 went to bed, then she got back up and was walking in the hallway. V6 said I don't know if R3 has ever fallen, she is pretty new.

On 9/16/22 at 1:50PM V8, CNA, said on 9/15/22 she saw R3 at the nurse's station trying to get up. V8 said R3 said she was hungry and V8 said she told R3 breakfast is on the way. V8 said then the

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S9999	Continued From page 9 trays arrived on the unit. V8 said V9 and V16, both CNAs, were passing trays and V8 said she left to do her rounds, walking with her back to the nurse's station and R3. V8 said then V9 told her we need a nurse. V8 said she then saw R3 on the floor. V8 said following R3's fall she has not been told what the new fall prevention intervention is for R3. V8 said the residents have a care plan behind the doors that include safety interventions. On 9/16/22 at 2:04PM V9, CNA, said she was on the unit passing meal trays on 9/15/22. V9 said the night shift had gotten R3 out of bed and into her wheelchair because R3 was a fall risk. V9 said she was told R3 was trying to get up and walk so they put R3 at the nurses' station. V9 said she was in a resident room and heard a "boom" and someone said there was a fall. V9 said she came out of the room and saw R3 on the floor. V9 said she had seen R3 standing up about 10 minutes before R3 fell. V9 said R3 thinks she has to make a call and go to work. V9 said when R3 gets restless she moves around and tries to use the phone. V9 said V8, CNA, was on a different unit when R3 fell. V9 said V7 and V16 were in resident rooms and "nobody was at the nurses station." The surveyor clarified with V9 if there was no one at nurses' station with R3? V9 said "correct, she (R3) was the only one there." On 9/16/22 at 2:36PM V11, Restorative Nurse, said when a new resident is admitted we complete a restorative assessment. The assessment includes how the resident transfers, range of motion ability, their walking ability, and any assistive or fall prevention devices needed. V11 said if a resident is admitted with a fall history, confusion, or attempting to ambulate when needing assistance, we will consider the resident a high fall risk and they will be placed on	S9999		

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the fall prevention program. V11 said staff is notified of high fall risk residents with a blue star on the door. V11 said staff is notified of the fall program at orientation. V11 said residents at the desk require frequent observation or to be in sight of staff. V11 said observation at the desk was not effective for R3. V11 said before 9/15/22, R3 was a fall risk because she gets up without assistance. V11 said staff would know R3 is a fall risk by having her. V11 said R3 was a new admit so we were in the process of getting her care plan in place. V11 said I have not done any of the fall interventions for R3, yet. V11 said after the fall risk assessment, if the resident is at risk, I put in the fall care plan and the interventions.

On 9/20/22 at 9:45AM V12, MDS Nurse, said the Interim care plan should be in place in 48 -72 hours, from admission. V12 said the purpose of the interim care plan is so that care will be delivered, especially if there are risks involved. V12 said if a resident is at risk for falls then the care plan will be implemented for falls.

R3's Fall Record provided by the facility dated 9/15/22 notes R3 had an unwitnessed fall without injury.

Fall Risk Assessment completed on 9/15/22 at 9:09AM notes R3 has balance problems while walking, decreased motor coordination, and no history of falls in the last 3 months. R3 is noted to be a High Risk for falls. There is no fall risk assessment completed on admission, 9/10/22.

Initial Baseline Care Plan dated 9/10/22 notes R3 will be free of injury. Assess for risk factors, Orient to room and call light use, and assess history of falls. Review of further Care Plans, 6 pages provided, does not include interventions to

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prevent falls.
Care plans do not include interventions when R3 attempts to get up unassisted. R3's care plan does not include the contributing factors identified on her fall risk assessment.

A facility provided hospital record with a printed date 8/24/22 notes R3's family concerned about R3's memory loss and complaints of fall in house several weeks to month ago. Record states "legs gave out."

On 9/20/22 at 10:51AM, the surveyor asked V11 what score she used to determine to place stars on the resident doorways. V11 said it depends on the fall risk assessment score and if they have fallen. The surveyor asked V11, do you have a documented consistent plan to follow stating when the stars will be put on the door? V11 responded, no.

On 9/20/22 at 11:18AM V13, Director of Nursing was interviewed. V13 said the star is used to let staff and family know that the resident is a high fall risk. V13 said if we know the patient is trying to get up alone, when they are newly admitted, then they have them at the nurses' station, or in activity to see what interventions will be put in place. V13 said residents are placed at nurses' station to closely monitor. V13 said I wasn't here (in the facility) when R3 fell. V13 said we are not going to prevent all falls. The surveyor provided V13 with R3's Interim care plan for review. V13 said we probably need to add more to it, this is a corporate form. The surveyor asked V13 how the staff know if a new admission is at risk for falls? V13 said the CNAs will do room to room report. V13 said this is a verbal report. The surveyor asked what protocol is used to identify fall risk residents to the staff. V13 said "I don't have an

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S9999	Continued From page 12 answer." V13 said when a resident is admitted the computer interventions are put in place by the nurses within 7 days. V13 said the light bulb symbol is used if the resident is not able to use their call light. On 9/20/22 after the 11:18AM interview with V13, DON, the surveyor requested copes of R1's and R3's Transfer Sheets. These were not provided to the surveyor. On 9/20/22 at 12:46 PM V12, MDS Nurse, said quarterly is defined per Resident Assessment Instrument (RAI) Manual as every 90 days or earlier. V12 said if an assessment is done in October, the next one is due in January, then April, then July, and then in October. V12 said in 1 year the resident should have at least 4 assessments completed. The facility Falls Prevention and Management policy revised 3/2022 notes the purpose of this policy is to support the prevention of falls by implementation of a preventive program that promotes the safety of residents based on care process that represent the best ways we currently know of preventing falls. The falls prevention and management program is designed to assist staff in providing individualized, person centered care. The falls prevention and management program provides a framework and tools to identify and communicate about a residents risk of fall. Fall Prevention Practices includes: universal fall precautions, standardized assessment of fall risk factors, care planning and interventions to address risk factors. The fall risk assessment is completed quarterly, with significant change in condition, and following a fall. (no violation)	S9999		

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 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 2 of 2 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. These requirements are not met as evidenced by: Based on interviews and records reviewed the facility failed to report a fall with serious injury for 1 resident (R1) within 24 hours. This failure affected 1 of 3 residents reviewed for reporting of serious injury. Findings include: According to progress notes and incident reports dated 8/13/22, R1 sustained a fall on 8/13/22. R1 suffered a laceration to his forehead and was sent to the hospital for an evaluation. Progress notes dated 8/14/22 at 4:52AM note R1 returned from the hospital. R1 noted with 1 suture and laceration to his scalp. On 9/20/22 at 11:08AM V13, Director of Nursing, said R1 had sutures when he returned to the facility. V13 said, I reported to IDPH within 24 hours of a resident returning from the hospital. V13 said I was not made aware that R1 was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 transferred to the hospital. V13 said I know it is greater than 24 hours before IDPH was notified. V13 said she was not made aware until Monday (8/15/22) that R1 had sustained an injury from his fall on 8/13/22. Review of the facility provided electronic mail submission to IDPH dated 8/15/22 at 12:13PM for R1. Facility provided final report sent to IDPH 8/18/22 notes upon return from hospital R1 noted with 2 sutures to left side of forehead. The facility policy revised on 4/2019 states The Department of Public Health will be notified of any serious accidents or incidents in accordance with the Skilled Nursing and Intermediate Care Facilities Code 300.690 (b) (c). (C)	S9999		