PRINTED: 03/09/2023 FORM APPROVED

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C IL6008270 B. WING 02/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE GENERATIONS AT ELMWOOD PARK ELMWOOD PARK, IL 60707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint 2390231/IL155173 S9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)5) Section 300.610 Resident Care Policies 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 The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological Attachment A Statement of Licensure Violations well-being of the resident, in accordance with each resident's comprehensive resident care

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/09/2023 FORM APPROVED

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6008270  NAME OF PROVIDER OR SUPPLIER			LE CONSTRUCTION	COM	E SURVEY IPLETED
NAME OF					02/	02/03/2023
	34	THE NAME OF THE PARTY OF THE PA	ST GRAND A	STATE, ZIP CODE		
GENERA	ATIONS AT ELMWOO		DD PARK, IL			
(X4) JD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		HOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 1	S9999			
	care and personal	d properly supervised nursing care shall be provided to each to total nursing and personal resident.	÷,	* * \		
2470.3	c) Each direct and be knowledged respective resident	care-giving staff shall review able about his or her residents' care plan.		v e		
92	nursing care shall i	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:				
	pressure sores, hea breakdown shall be seven-day-a-week	ogram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not		: :	*	
	develop pressure so clinical condition de sores were unavoid pressure sores sha services to promote	ores unless the individual's monstrates that the pressure lable. A resident having li receive treatment and healing, prevent infection, essure sores from developing.				
	These requirements by:	s were not met as evidenced				
i t f	review, the facility fainterventions to prevestions to prevestions (R72, R24 for pressure ulcer in	vent pressure ulcers for two 6) of five residents reviewed a sample of 30. This failure veloping a stage 3 pressure				
F	Findings Include:			* 8		*

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C B. WING IL6008270 02/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE **GENERATIONS AT ELMWOOD PARK ELMWOOD PARK, IL 60707** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 R72 laying in his bed with V4 - Registered Nurse (RN). R72 did not have a heel protector on. On 2/1/2023 at 12:55 PM, V4 said that the heel protector should have been on. On 2/2/2023 at 10:45 AM, surveyor observed R72 laying in his bed with V10 - (Wound Care Nurse). R72 did not have a heel protector on. On 2/2/2023 at 10:47 AM, V10 said that the heel protector should have been on. On 2/2/2023 at 4:00 PM, V2 (Director of Nursing) said, R72 should have his heel protector on when resting in bed. R72 is admitted with a diagnosis not limited to chronic respiratory failure, major depressive disorder, peripheral vascular disease, and unspecified-arterial insufficiency. Review of R72 physician order dated 3/31/2020 documents, "Bilateral Heel protectors q shift." Review of R72 care plan dated 3/21/2019 documents: "R72 is at a very high risk of skin breakdown related to Braden Score of below 12, level of dependence, incontinence, immobility, impaired cognition, decreased tissue perfusion. impaired circulation, poor nutritional status. presence of non-removable devices (trach, gastric tube), presence of scar tissue, hx of wounds, decreased sensory of perception, and presence of severe contractures to bilateral lower extremities. 2. R246 has a diagnosis not limited to hereditary and idiopathic neuropathy, hypertension, and type

2 diabetes.

PRINTED: 03/09/2023 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDED/SUPPLIED/CLIA			FORM APPROV			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6008270		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED		
						NAME OF PRO
GENERATIO	ONS AT ELMWOO	D PARK 7733 WE	ST GRAND A	WENUE	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH AND CORRECT TO THE APPOPER OF THE PROPERTY		D.BE COMPLET	COMPLETE
S9999 C	ontinued From pa	age 3	S9999		*4 <sub>1</sub>	_
O2 st	::13 PM documer age 3 pressure ul	note dated 12/1/2022 at hts that R246 was assessed, cer noted to right outer foot .5cm. New orders noted.	90 			2
sh du rig dif ch ch sai	e was the one the e to x-ray result the ht foot. V20 said ferent floor. V20 secks but cannot re eck on R246 whe d that R246's wo	5 PM, V20 (Nurse) said that at sent R246 to the hospital hat showed dislocation of the that she usually works on a said that she does weekly skin remember if she did skin on she took care of her. V20 und should have been advanced to stage 3.			30 30 31	
ne not tim sai bef R2 the nur trea duri	tatarsal location iced a dislocation on 12/1/2023, and that wound show one it advanced the first table of table	tated she saw R246 for right for wound treatment and and the wound for the first and it was at stage 3. V10 and have been observed to stage 3. V10 said that ectors in place but R246 kicks nat she always calls the R246 before her wound assess her pain before, viding wound care treatment.	22			
pillo not that red. and	c care of R246 are some she took to started getting ws were used to recall if R246 had R246 was admit V21 noticed the wound care nurs	PM, V21(CNA) said that she and that she gave R246 bed a care of her. V21 said that red at the ankle bone and separate her legs. V21 does a heel protector. V21 said ted and the metatarsal was wound and notified the nurse se was notified.  PM V2 said that she expects skin and notify the nurse				

STATEME	Department of Public NT OF DEFICIENCIES	Health (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	200	APPROVED	
AND PLAI	OF CORRECTION	IDENTIFICATION NUMBER:		G:	COM	(X3) DATE SURVEY COMPLETED	
	IL6008270		B. WING			C 02/03/2023	
NAMEOF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY	, STATE, ZIP CODE			
GENER	ATIONS AT ELMWOOI	PARA	ST GRAND DD PARK, IL				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	LD BE COMPLETE	
S9999	Continued From pa	ge 4	S9999	**			
> ;	and also document	rse of any skin care alteration, in the observation sheet. V2 should have been discovered to stage 3.	1	2 XX W 13+12		* §	
#: #:	said that when she 12/6/2023, she stag said that the wound	2 PM, V19 (Wound Doctor) assessed R246's wound on led the wound at stage 4. V19 should have been discovered a 3, which was when it was acility staff.	4		8	is the second se	
	document R246 at s	cale for initial assessment score of 13.		s s	U s	28.2 87 82. 29.2 87	
	Policy: Pressure Ulc Objective: 1. Reside	de weekly skin assessment. eer Prevention Protocol ents will be assessed to factor(s) for pressure ulcer	2	*	ar Tr	746 746	
	4. Interventions necessified integrity or to promount on the plan of care individual needs and 6. Residents will have documented utilizing	re their skin checked and Treatment Administration	¥C		92 92		
	Record. This skin ch minimum of weekly.	eck will be performed at	ii	V X 3.8	<u>.</u>		
5	(B)	92		* = 3 I	;. e		
8						D.	

Illinois Department of Public Health STATE FORM