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S 000	Initial Comments Investigation of Facility Reported Incident of May 31, 2024/IL174377	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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 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.	S9999		

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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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure the wheelchair locking mechanism was engaged and failed to supervise one high risk for falls resident (R1) in a sample of 3 residents. This failure resulted in R1 falling out of an unlocked wheelchair while sitting in an unsupervised dining room. R1 sustained bruising to the left side of face and a cut above her left eye which, required hospital evaluation and 4 sutures above left eye.

Findings include:

Facility's reportable to state agency regarding R2 documents in part: Date of Occurrence: 05/31/24,

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R1 was noted on dining room floor in front of her wheelchair. R1 was laying on her left side and noted with a small cut to above her left eye. Nurse on duty provided first aid. R1 was sent to local hospital for further evaluation. R1 returned from local hospital with four sutures above left eye. Interviews: V10 (Activity Aid) states R1 participated in a group activity. After the activity V10 transported R1 out of the activity room and was instructed by nurse to bring R1 in the dining room. V10 placed R1 by the table in the dining room. V10 could not recall if she locked both sides of the wheelchair. When V10 returned in the dining room with another resident, the incident had already occurred. V12 (Registered Nurse/RN) states he was by the medication cart outside the glass window of the dining room. V12 heard R1 shout and observed that R1 was on floor in dining room. R1 was laying on her left side in front of her wheelchair and partly under the table. V12 noted her right leg was caught in the leg rests of her wheelchair. V12 removed the wheelchair and repositioned R1 on her back. V12 noted the wheelchair was locked on one side. V12 noted R1 had a small cut above her left eyebrow and skin discoloration under the left eye. He provided first aid while staff called 911 and he took the vital signs and within her baseline limits. R1 was alert to her norm with active ROM to all extremities. R1 returned from ED the same evening with negative x-rays and negative head CT. R1 had 4 sutures placed to her left eyebrow area. V11 (Licensed Practical Nurse/LPN) was at the nurses' station receiving a report when she directed the activity aid to assist R1 to the dining room. V11 was next alerted of the incident. V11 responded and noted that V12 was assessing R1. V11 observed R1 was alert to her norm, moving all her extremities.

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R1's diagnoses includes Dementia with other behavioral disturbances, Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere, Anemia, anxiety disorder, major depressive disorder, essential hypertension, heart failure, glaucoma, osteoarthritis, vertigo of central origin. BIMS score dated 5/08/24 - 3 indicating severe impairment.

Nurse's Notes for R1 dated: Nursing Date & Time 05/31/2024 04:54 PM e-Signed by V11 Created Date & Time 05/31/2024 05:32 PM show at 3:20 pm while NOD (Nurse on Duty) was taking report, resident brought to nurses' station by activity directed by NOD to place in dining room by the small table activity said yes. In 1 minute - 2 minutes prior, co-nurse heard (a) sound in dining room, immediately attend noted resident fell of the wheelchair. Then everyone attended noted resident in the floor on her left side has injury on left side of the face. Her wheelchair wasn't lock. 911 called, MD notified. Residents send to Local Hospital ER. At 3:36 pm resident Left the facility alert. Report given to ER nurse. Emergency contact POA notified.

Nurse's Note for R1 dated: Nursing Date & Time 05/31/2024 11:34 PM e-Signed by V11 Created Date & Time 06/01/2024 12:04 AM show at 7:30 pm, receive phone call from Local Hospital resident is coming back to the facility. At 8:15 pm resident arrived via (local ambulance service) from the hospital. Resident alert at her baseline. Resident has laceration with 4 absorbable sutures, no need to for call for removal they will dissolve. There is no orbital fracture, no nasal bone fracture, no mandibular fracture, or dislocation with instruction to the remove the gauze in the morning and put warm towel at time.

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R1's (03/17/2024) Fall Assessment documented in part: score of 15, high risk for falls.

R1's care plan (Start Date 08/07/2023) show R1 is at risk for fall related to impaired judgment, confusion, history of falling, muscle weakness, dementia, anxiety, dermatitis, back pain, HTN, GERD, glaucoma, and vertigo. Approach (Start Date 5/31/2024): resident's wheelchair is to be locked at all times. Approach (Start Date 5/14/2024): Falling leaf program. Approach (Start Date 9/24/2023) Observe frequently and place in supervised area when out of bed. Approach (Start Date 9/21/2023): Give resident verbal reminders not to ambulate/transfer without assistance.

On 6/21/2024 at 11:51am surveyor observed R1 sitting in wheelchair facing television with wheelchair wheels locked. R1 was dressed, well groomed, and hair combed wearing shoes. R1 was awake and trying to put bib in mouth. R1 had an old dark purplish bruise to left lower side of face. R1 was able to open her eyes. R1 primarily speaks Spanish and CNA (Certified Nursing Assistant) interpreted but was unable to understand R1. R1 was able to nod her head that she was okay. R1 appeared to be sleeping on and off. Both hands of R1 are contracted. R1 did not remember incident of 5/31/2024.

On 6/21/2024 at 11:55am V4 (LPN) stated (in part), R1 is okay. We get R1 up before breakfast, if she gets sleepy, we will put her back to bed. After lunch she is usually sleepy, and we put her to bed. Surveyor asked V4 if she was aware of the incident on 5/31/2024 when R1 fell. V4 stated, yes, I was R1's day shift nurse. V4 stated the activity aide brings residents from the activity room and forgot to lock the wheelchair and R1

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fell. R1 cannot stand but she moves around a lot, and she needs a lot of supervision. R1 is unable to walk. Surveyor asked what can happen if the wheelchair is not locked and R1 is sitting in the wheelchair. V4 stated, R1 moves around and leans forward and that is how she fell on R1's face, because the wheelchair was not locked. The activity aide put her in the dining room at a table and did not lock the wheelchair wheels. Right after R1 fell, the activity aides were trained on how to avoid falls and make sure to lock wheelchair wheels. Surveyor asked V4 should the dining room be supervised when residents are in the dining room. V4 stated, "Yes always have to supervise". V4 stated, I did not see R1 fall, I was giving report at the nurses' station when she fell, and we ran into the dining room. Surveyor asked if anyone was supervising R1 in the dining room. V4 stated, "No".

On 6/21/2024 at 12:52pm V8 (CNA) stated, I take care of R1 everyday Monday thru Friday, 7am to 3pm. R1 is Spanish speaking. She is total care. I have to do everything; I do everything for her right away. R1 cannot walk, cannot self-propel herself in the wheelchair. I push her in the wheelchair and lock both wheels. R1's hands cannot move chair or take the wheelchair lock off. R1 needs help transferring to the bathroom or anywhere. Surveyor asked V8 if she was working the day R1 fell on 5/31/2024. V8 stated, yes but I was off when R1 fell. It happened about 3:30pm. I am done at 3:00pm, so I am not sure what happened. Someone told me R1 fell out of the wheelchair and wheels were not locked.

On 6/21/2024 at 1:58pm surveyor asked V10 (Activity Aide) what happened on 5/31/2024 when R1 fell. V10 stated, I was done with activity and when I am done, I get the residents to the dining

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room. I gave R1 to the nurse, and the nurse said to put R1 in the dining room. When I put her in the dining room, I went to take more residents and after a few minutes, R1 fell, and the nurse and the CNA took care of her, but I do not know if it was my fault because I was done with her. Surveyor asked V10 when you put R1 in the dining room, did you lock R1's wheelchair. V10 stated, "I do not think I locked both locks on the wheelchair. I remember I locked one. I do not remember if I locked both, but I remember I locked one. I (V10) did not see R1 fall, I do not stay in the dining room". After the incident they asked me questions, I said the truth I put her in the dining room, and she fell. I told them what I told you. I saw how people lock the chair. I have worked here for about 3 months. Surveyor asked V10 who was supervising in the dining room when you left R1. V10 stated, no one I had to go and get other residents. Surveyor asked V10, when you started your job here, did they show you how to use a wheelchair and how to lock the wheelchair, so it does not move. V10 stated, "No." When I started it was not for one day, you learn, and you learn. Recently, they showed me, and I must make sure the chair is locked. Recently, they talked about making sure both wheels on the wheelchair are locked. V10 was asked did they show you about the wheelchair and how to lock the wheelchair after R1 fell. V10 stated, "Yes." Surveyor asked, V10 are you able to transport residents by yourself. V10 stated, yes, I transport by myself.

On 6/21/2024 at 3:10pm V11 stated, I take care of R1 every day that I am here. I remember the incident that occurred on 5/31/2024 when R1 fell. My shift starts at 3:00pm I was at the nursing station getting report. During the report there was an activity aide taking residents to the dining

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room. The activity ended so R1 was going back to the dining room. When V10 passed by with R1 she was to park her by the wall. I said this resident (R1) can sit in the dining room she has a special table there that is lower than all of the tables due to her size and height because she cannot see with something in front of her because she has tendency to lean forward. V10 replied to me, I know. V10 continued with R1 to the dining room so while I was still taking the rest of the report from the nurse. Within less than 2 minutes my co-nurse was by the medication cart, and I (V11) saw him (V12) run into the dining room, and he noted R1 fell. All of the nurses went to the dining room, and he (V12) noted the resident was placed at the wrong table and the wheelchair was unlocked. I believe both wheels because when she leaned forward and fell. The wheelchair wheeled away from her. R1 is unable to move herself in the wheelchair, she just goes forward. She is Spanish speaking and has table at level that will remind her not to fall. That particular day V10 put her at the wrong table, and nothing was in front of her to help R1 see. R1 noted had blood come out by left eyebrow and bruises on the left cheek. We called 911 right way and did vital signs. I (V11) put pillow under her head and monitored her (R1) vital signs and did not leave her (R1) side until 911 came and put her on the stretcher. Surveyor asked V11 What should have been done with R1 if there was no staff in the dining room yet. V11 stated, "R1 has to be with a CNA. I am not sure if there was a CNA in the dining room, I was in report and I do not know if V10 knew if there was a CNA in the dining room. A CNA is supposed to be in there to monitor residents. When R1 was brought into the dining room V10 should have position R1 at the lower table where she sits every day and locked both of her wheelchair wheels. When R1 leaned

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forward she went on the floor and the wheelchair went back because there was nothing in front of her. Whoever wheels the residents if the resident is going to remain in the wheelchair both wheels should be locked before you turn from the resident. It is a no - no to leave the wheelchair unlocked". There has been recent education regarding falls and fall prevention and included using a wheelchair and making sure wheels are locked. Sometimes no one can understand what R1 is saying. R1 is unable to propel herself or make her needs known. The nurse that first saw R1 said he heard the noise. When R1 returned from the hospital she had sutures on left side by eyebrow, I believe it was 4 sutures that will melt on its own. She has not had any fall since the 5/31/24 fall. The way she is supposed to be position is safe for R1. V10 on that day did not say in front of me that the wheels were locked because she realized that the wheels were not locked.

On 6/21/2024 at 3:35pm V12 (RN) stated, I remember the incident when R1 fell I think it was a Friday. When I make my cart for my shift, I heard crying and looked in the window and R1 was on the floor. I heard the cry. I ran there and the CNA came and removed the wheelchair and put straight. The left eyebrow was bleeding. I got a towel and put pressure. R1's nurse came, and the other nurse came, someone took vital signs, and someone called 911. V10 put R1 at the wrong table. She has a small table there and she was moving and sometimes she moves like that, and I think the wheelchair was not locked. R1 always leaning forward and moving so I do not think the wheelchair was locked. I did not check the wheelchair because I was putting pressure on the site. R1's wheelchair should have been locked and R1 should have been put at the small

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table when placed in the dining room. V10 said, knew the table R1 was supposed to go to but she did not put her at the low table, I am not sure what happened that day. We have had education about falls, fall prevention and how to use a wheelchair. Education included to make sure both wheels are locked on the wheelchair. R1 cannot move herself in the wheelchair but she does move. I do not believe she has fallen since the 5/31/24 fall. Surveyor asked if anyone was in the dining room when R1 fell out the wheelchair. V11 stated, I did not see anyone.

On 6/21/2024 at 4:10pm V13 (CNA) stated, I was assigned to her that day, but I came late that day. I was putting diapers and sheets on my cart, so I did not see anything. I saw the nurse running to the dining room. There were nurses and CNAs in the dining room with R1 when I walked in R1 was on the floor. I think she was in a wheelchair. V10 was transporting the residents to the dining room. I do not know what happened, but R1 fell on the floor. I do not know if the wheelchair was locked or unlocked. R1 cannot walk, she can talk but cannot understand what she says. She is only Spanish speaking. R1 is confused and needs total care. R1 is not able to propel herself in the wheelchair. The nurses called 911 and R1 was sent to the hospital. R1 moves a lot in the chair and tries to get up. R1 has a small table for her, and the wheelchair has to have both brakes on. I have had recent education on falls and fall prevention and how to use wheelchair and position and checking to see if resident has to go to the washroom. They have a leaf on the door that indicate they are a fall risk. I do not believe anyone was in the room with her because V10 was talking residents from one room to the dining room. There was only one activity aide person transferring the residents. Someone is supposed

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to be in the dining room at all times if any resident is in the dining room.

On 6/22/2024 at 9:57am V14 (Activity Director) stated, I was not there but I was told V10 was transferring R1 from the activity room on the floor to the dining room. V10 went to the nursing station and the nurse told V10 to put R1 in the dining room. V10 took R1 into the dining room and locked one of the two wheelchair wheels. R1 apparently leaned forward and fell out of the wheelchair. That is pretty much all I know. Surveyor asked, V14 what is the orientation for Activity Aides regarding the use of wheelchairs. V14 stated, "Residents that are in wheelchairs should be transferred by the nurse or the CNA. Unfortunately, during the time this incident occurred around 3:00pm the nurses and CNAs are doing shift change so no one was able to assist my staff to bring R1 to where the resident needed to be". Surveyor asked, V14 if activity aides have training on how to use a wheelchair. V14 stated, "Yes and no, they understand the leaf on the door or wheelchair means fall risk and they understand their is supposed to be assistance to transfer the resident to and from. I do not know how long nurses and CNAs have not been assisting my staff". They (Activity Aides) recently had education on wheelchairs and the person explained to my staff the importance of locking the wheels on the wheelchairs. Surveyor asked V14 if this was done before or after the incident that occurred on 5/31/2024. V14 stated, "Unfortunately, this was done after R1 fell. Prior to that I (V14) do not know when the last time was, they had proper training on that (regarding wheelchairs)". V14 further stated, "Prior to that incident on 5/31/2024 I (V14) had mentioned to my activity staff that the CNA or nurse should be helping them (activity staff) move residents to and

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from the activity room to the residents' room or dining room". The staff are usually pretty good at doing that.

On 6/22/2024 at 10:25am V14 stated, "The main reason the CNA or the nurse always helps with the transfer is supposed to have a staff member watch the residents in the room, we always want to make sure the staff member is watching the resident so incident that happened does not happen. Because it is a distance and if only 1 person is going back and forth who is watching the resident anything can happen in a short amount of time. That is why the CNA or nurse helps transfer back and forth. At that time no one was in the dining room. The nurses were at the nurses' station, but no one was in the dining room and V10 was putting residents at the table per the nurse's request". V14 stated, V10 has only been here for a few months. This is all new to her. I was hired the same time she was, so I did not have anything to do with her (V10) training.

On 6/22/2024 at 11:07am surveyor asked V2 (Director of Nursing) regarding incident that occurred on 5/31/2024 with R1. V2 stated, R1 was in an activity and V10 was transferring her (R1) they brought R1 to the nurses' station and V11 directed V10 to take R1 to the dining room. When I interviewed V10 she stated she placed R1 at a table in the dining room. When I (V2) asked if she locked the wheelchair, she said she thought she did. Another aide was also transferring residents into the dining room too. V12 said he (V12) was standing at the med cart near the dining room and heard R1 cry and when he (V12) looked up R1 was on the floor. V12 said he (V12) went in and one of her legs appeared tangled in the footrest of the wheelchair and he (V12) removed the wheelchair, and he thought

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	IL6006837	A. BUILDING: _____ B. WING _____	C 06/23/2024

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
S9999	Continued From page 12	S9999		

one side was locked but was not sure if the other side was locked. V12 said R1 had an open wound above left eyebrow and V12 attended to that, and other staff came in they called 911 and got vital signs. R1 was alert to her norm. V12 provided first aid and the ambulance came and took R1 to hospital and he notified the POA and MD. Surveyor asked V2 if there were staff in the dining room at the time of the incident. V2 stated, "No one said they were in the dining room. A CNA and V10 were transporting residents to the dining room from activity room". Surveyor asked V2 what the training for use of wheelchairs for activity aides is upon hire. V2 stated, during on-boarding for everybody one of the on boarding processes is discussing fall and look for fall risks and it is everyone's responsibility to prevent falls. (i.e. remove boxes on floor, footrest on wheelchairs, locking wheelchairs) CNAs and nurses get more in-depth training. If wheelchair is not locked, resident can try to stand, and the wheelchair could roll away and when the resident tries to sit down, they could fall. Activity aides are able to transfer residents in their wheelchairs. Surveyor asked V2, how do activity aides know if resident is a fall risk. V2 stated, they are informed by the staff and by the binder we put in place. Also, V14 their supervisor is present during morning meeting, and he brings information to activity staff. Restorative also does training, and we did in-service with all staff regarding falls and how to use locking wheelchairs.

On 6/22/2024 at 1:46pm surveyor asked V1(Administrator) regarding the incident that occurred on 5/31/2024 with R1. V1stated, I was here but not on the unit. I heard from nursing she (R1) was going to be sent out to the emergency room. I (V1) asked what happened, and I (V1) was told V12 was the first one on scene, they

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said V12 did not witness fall. V11 was the nurse for R1, and I (V1) asked her (V11) what happened, and she (V11) told me that activities (V10) transported R1 into the dining room after activities ended. V1 stated, "I brought V10 down and talked to her and asked V10 what happened. V10 told me they were doing activities in the corner room and activities was over, so they started to transfer the residents over to the dining room. I asked V10 did you lock the chair because V11 or V12 did assessment and the way the chair was positioned felt chair was not locked. I asked, did you lock the chair, did you lock both locks and V10 said, I believe I did, and I asked her are you sure and V10 stated, I do not know. I do not remember". I remember R1 going out after that then V2 did investigation for the fall. Surveyor asked V1 who can transport residents in wheelchairs. V1 stated, any staff or family member can transport resident throughout the facility. Surveyor asked, are staff given education on how to transport residents in wheelchair. V1 stated, "We did after the fall, but I am not sure if it was done before the fall. I know we did education on the wheelchair policy earlier in the year". Surveyor asked when the incident happened on 5/31/2024, what staff member was in the dining room at this time. V1 stated, I did not ask who was in the dining room to be honest, but if residents are in the dining room there should be supervision.

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 for residents. Provides training/education and in-servicing to employees upon hiring, during skills validation events, monthly and annually.

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S9999	Continued From page 14 The facility's Fall Prevention and Management Policy revised on 12/23 shows (in part), "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." The facility's Wheelchairs policy rev. July 2023 shows (in part) Objective: 1. To provide a safe means of transport for residents. Procedure: 2. Lock wheels. "B"	S9999		