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 09/05/2018

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

(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 Complaint Investigation 1895544/IL105220 1895714/IL105423	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide an adequate amount of staff assistance for safety during the provision of care. This applies to 2 of 3 residents (R1, R2) reviewed for falls in a sample of 7. This failure resulted in R1 falling off the side of the bed and incurring a fractured right hip requiring hospitalization and surgery.

Findings include:

1. R1's Resident Face Sheet dated September 4, 2018 documents R1 with diagnoses to include Muscle Weakness and Dementia. Minimum Data Set dated July 5, 2018 documents R1 requiring the extensive assistance of two staff for bed mobility.

R1's Event Report dated August 17, 2018 at 5:45pm, completed by V14 (Nurse), documents R1 fell out of bed at 5:40pm.

On September 4, 2018 at 11:18am, V14 stated V16 (Former Nursing Assistant) yelled for V14 to come help in R1's room. V14 stated when V14 entered R1's room R1 was on the floor between the bed and the wall with the bed in a partially elevated position. V14 stated V16 reported R1 fell when V16 was providing incontinence care; V16

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S9999	Continued From page 2	S9999		

had rolled R1 onto her side facing away from V16 and V16 told R1 not to move. R1 then reached out for something causing R1 to fall off of the bed onto the floor on the side which was unattended by staff. V14 stated R1 would reach for items and V14 should have had a second person on the other side of the bed to assist during care of R1. V14 demonstrated R1's position in the bed right before the fall as described by V16.

On September 4, 2018 at 12:58pm, V17 (Nurse Practitioner) stated she was informed by V14 that R1 had fallen out of bed when a nursing assistant was cleaning R1. V17 stated it was reported to her only one nursing assistant was providing care to R1 and while providing care R1 reached for an item and fell from bed. V17 stated R1 requires the assistance of two staff persons, one on each side of the bed for safety. V17 confirmed this was a preventable injury. V17 stated as a result of this fall R1 was admitted to the hospital where R1 was diagnosed with a hip fracture which required surgery.

R1's Resident Progress Notes dated August 18, 2018 documents R1 admitted to the hospital with a diagnosis of a right hip fracture.

2. R2's Resident Face Sheet dated September 4, 2018 documents R2 with diagnoses to include Hemiplegia affecting right dominant side, Weakness, Amputation above right knee, and Alzheimer's Disease.

On August 31, 2018 at 11:28am,V20 (Nursing Assistant) raised R2's bed with a scooped air mattress to an elevated position and began to provide care to R2. During this care V20 turned R2 onto her right side away from V20 and cleansed R2's buttock area without staff support

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S9999	Continued From page 3 on the other side of R2. V20 then left the bedside to go to R2's closet for more wipes. V20 then rolled R2 onto her left side without staff support on R2's other side and cleansed R2's posterior buttock area further. On August 31, 2018 at 3:00pm, V1 (Administrator) stated for safety two staff members should have been providing care to R2. R2's Minimum Data Set dated August 24, 2018 documents R2 as requiring the extensive assistance of 2 staff for bed mobility. The Fall Reduction Program dated May 2017 documents the facility will implement appropriate interventions to provide necessary supervision and assistive devices as necessary. (A) (2 of 2) 300.1210b) 300.1210d)1) 300.1210d)2) 300.3240a) 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	S9999		

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S9999	Continued From page 4 resident to meet the total nursing and personal care needs of the resident. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to provide physician ordered dosing and monitoring of anti-coagulant medication. This applies to 1 of 3 residents (R2) reviewed for anti-coagulant use in a sample of 7. This failure resulted in R2 being hospitalized with a diagnosis of supratherapeutic INR (International Normalized Ratio) and a Gastric Bleed. Findings include: R2's Laboratory Report for INR and PT (Prothrombin Time) dated July 18, 2018 documents R2 with an elevated PT of 34 (normal range 12.5-15.1 seconds) and an elevated INR of 3.4 (normal 0.8-3.0 Ratio). There is no evidence in the clinical record of any further PT or INR test results between July 19, 2018 through August 1,	S9999		

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S9999	Continued From page 5 2018 at the facility. R2's Order History Report from June 1, 2018 to September 4, 2018 documents no medication changes or PT and INR tests were ordered between July 19, 2018 to August 1, 2018. Resident Progress Notes dated August 2, 2018, completed by V17 (Nurse Practitioner), documents R2 having bloody stools and to be sent to the hospital for evaluation of a potential gastrointestinal bleed. On September 4, 2018 at 12:58pm, V17 (Nurse Practitioner) stated V17 was called regarding R2's elevated PT and INR test on July 18, 2018. V17 stated a verbal order was provided to an unknown evening shift nurse to hold R2's Warfarin and repeat the PT and INR test on July 20, 2018. V17 stated that was not done and R2 continued to receive the same dose of Warfarin up until R2 was hospitalized on August 2, 2018. R2's July and August 2018 Medication Administration History reports documents R2 received Warfarin 4 milligrams daily July 5, 2018 through August 1, 2018. On September 5, 2018 at 8:25am, V21 (Physician) stated an elevated INR can be problematic causing bleeding for residents with a weak supply of blood to the gastric tract. V21 confirmed R2 was hospitalized with gastric bleeding and a significantly elevated INR which occurred after verbal orders given by V17 to facility staff were not followed. V21 stated residents receiving Warfarin are monitored individually based on the test results. V21 stated if residents are receiving Warfarin, PT and INR's are completed minimally every 72 hours if levels	S9999		

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S9999	Continued From page 6 are not therapeutic and every 2 weeks if therapeutic. R2's Hospital Emergency Room Report dated August 2, 2018 documents R2 presenting to the emergency room with blood in stools. This report documents R2 being admitted with a diagnosis of supratheraputic INR (10.7 ratio) and a Gastric Bleed. This report further documents due to the elevated INR Vitamin K and 2 units of blood was being administered for treatment. The facility policy Anticoagulant Therapy dated May 2017 documents anticoagulant medications and monitoring are to be administered per physician orders. (A)	S9999		