

Illinois Department of Public Health

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 C 01/19/2021
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NAME OF PROVIDER OR SUPPLIER GENERATIONS AT ELMWOOD PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE ELMWOOD PARK, IL 60707
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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
S 000	Initial Comments Complaint Investigation 2099869/IL129612	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide the necessary care and services by not assessing a resident on admission to the facility, assessing a resident with a change in condition, and obtaining vital signs as ordered for a resident returning from an eight day hospitalization for cardiac arrest for one of three residents (R7) reviewed for change in condition in the sample of 12.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Findings include:</p> <p>R7's face sheet showed a 48 year old admitted to the facility on November 27, 2020 with diagnoses including chronic respiratory failure with hypoxia, end stage renal disease, and dependence on renal dialysis, history of sudden cardiac arrest, right above the knee amputation, tracheostomy, and Type 1 diabetes.</p> <p>R7's history and physical (late entry dated December 2, 2020) showed R7 was scheduled for a right lower extremity angiogram where he developed cardiac arrest and required intubation. On October 27, a tracheostomy was placed. On November 1, 2020, R7 developed atrial fibrillation with RVR (Rapid Ventricular Rate) and a pulmonary embolism (blood clot in the lung). R7 was stabilized and sent to an acute rehab facility and then to the current facility for continuity of care.</p> <p>R7's face sheet showed R7's Respiratory Admission Assessment dated December 9, 2021 at 3:50 PM showed R7 was on a ventilator.</p> <p>R7's Physician Order Sheet (POS) dated December 9, 2020 showed to take nothing by mouth (NPO) and to check vital signs every shift. The POS showed R7 was a full code status.</p> <p>R7's progress note dated December 1, 2020 at 1:13 PM showed R7 was found unresponsive and without a pulse during dialysis at the facility. R7's progress note dated December 1, 2020 at 9:24 PM showed admission to a local hospital for cardiac arrest. R7's progress note dated December 9, 2020 at 11:08 PM showed R7 returned to the facility at 3:00 PM. There is no nursing assessment documented for this</p>	S9999		

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S9999	<p>Continued From page 3 admission back to the facility.</p> <p>R7's progress note dated December 10, 2020 at 2:48 AM showed the resident was still the same. R7's vital signs were documented in the nursing record on December 9, 2020 at 9:18 PM. No other vital signs were documented in R7's record by nursing until December 10, 2020 at 12:34 AM in a progress note. This progress note showed a temperature of 99.9 and the nurse was unable to obtain other vital signs (heart rate, respiratory rate, blood pressure).</p> <p>R7's December 10, 2020 at 7:15 AM progress note showed the resident was unresponsive, a code blue was initiated, CPR (Cardiopulmonary Resuscitation) was initiated and 911 was called. R7's 7:49 AM progress note showed R7 was pronounced dead.</p> <p>On January 16, 2021 at 2:15 PM, V2 (Director of Nursing) stated, "If a nurse is unable to obtain vitals (temperature, pulse, respirations, blood pressure) on a resident they should try doing it manually. The blood pressure machine doesn't always work. I would expect the nurse to do a head to toe assessment and listen to an apical pulse. That is not a good note. Sometimes the staff write vital signs on the 24 hour sheet. The 24 hour sheet is not part of the resident's record. If you can't get vital signs, you should start CPR."</p> <p>On January 17, 2021 at 12:39 PM, V17 (Registered Nurse/RN) stated, "If a resident is readmitted from a hospital stay, we do a head to toe assessment and do a narrative in the progress notes. There are packets in our electronic charting system for admission, readmission, and observation. This is where we document our assessment. If I was unable to</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>obtain a resident's vital signs, I would never, never stop trying. I would call the supervisor, the doctor, or send them back to the hospital. It's our protocol to do a head to toe assessment. It helps us understand their care needs. If there is no pulse on a resident, I would start CPR if they were a full code. If a resident returned to the facility after being hospitalized for eight days, they would be considered an admission."</p> <p>At 1:23 PM, V18 (Licensed Practical Nurse/LPN) said if she receives a resident back from a hospitalization, she fills out the admission packet in the electronic record. V18 stated, "This packet includes head to toe assessment data including skin integrity, vital signs, mental status, ventilators, etcetera. I would also document in the progress notes. If I couldn't obtain a resident's vital signs, I would call the supervisor, doctor, or ask another staff person to try. You don't just do nothing. A head to toe assessment determines and documents how the patient was received and what they require. It's the protocol to do an assessment. In general, it could be detrimental to a resident if an assessment is not done or if vital signs are not monitored."</p> <p>At 1:57 PM, V20 (R7's Physician) stated, "The facility is responsible to the resident, to provide the care and services ordered by the physician. You absolutely have to do an assessment on admission. It's nursing home protocol. It's the standard of care. There is no excuse for not taking and/or recording vital signs. If you can't get someone's vital signs, you should contact someone to recheck the resident or call 911." V20 said he was not notified staff were unable to obtain R7's vital signs.</p> <p>The facility's May 2017 Admission of a Resident</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Policy documented to complete the Nursing Body Assessment in its entirety in the admission Nursing Assessment in the electronic health record. Take TPR (temperature, pulse, respirations) and BP (blood pressure). Assess heart sounds, lung sounds, and bowel sounds. Assess resident's condition specific to the admitting diagnosis in addition to general nursing assessments and document findings. Obtain and process Physician's orders. Complete a comprehensive nurse's admission note in the medical record. Complete Admission/Readmission Assessment Observation in the electronic health record.</p> <p>The facility's March 2016 Change in a Resident's Condition or Status Policy documented the nurse will notify the resident's attending physician or physician extender when there is a significant change in the resident's physical, mental or psychosocial status.</p> <p>(AA)</p>	S9999		
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