Illinois Department of Public Health

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 12/19/2023

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 23910028/IL167336 2399693/IL166929	S 000		
S9999	Final Observations Statement of Licensure Licensure: 1 of 2 300.610a) 300.1010h) 300.1035a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	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	Continued From page 1	S9999		

change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1035 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment.

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.

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:

2) All treatments and procedures shall be

Illinois Department of Public Health

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S9999	Continued From page 2	S9999		

administered as ordered by the physician.

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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their policy in notifying a physician of a change in condition, the facility failed to ensure that oxygen was administered to a resident with labored breathing and to provide emergency life sustaining measures for one (R8) of five residents reviewed for change in condition and emergency life sustaining measures in a sample of 17. This failure resulted in R8 being found to be unresponsive, apneic, not receiving life sustaining measures due to the resident being in the wrong bed and R8 expiring.

Findings include:

Resident face sheet indicates that R8 was a 76 year old female, admitted on 10/20/2023 with diagnosis not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (Primary, Admission), Dysphagia following cerebral infarction. Peripheral vascular disease, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, aphasia following cerebral infarction, and hypertension.

On 11/30/2023 at 3:15 PM, V8 (Registered Nurse) said that when she was doing her rounds

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S9999	Continued From page 3 between 5:30 AM and 6:00 AM she noticed that R8 was having labored breathing. V8 said that R8 was in bed #2. V8 left the room and went to the computer to check R8's code status. V8 said that the resident in bed #2 was listed as Do Not Resuscitate (DNR) which was supposed to be R9, but it was not R9 in bed #2, it was R8 in the bed. V8 said that originally, she called 911 because R8 was still breathing. V8 told the paramedics that R8 is a DNR upon the paramedics' arrival and the paramedics told V8 that they will work on R8 until R8's DNR paperwork is provided to them. When V8 provided the DNR form, the paramedics verified the name and then stopped the resuscitation. V8 said that she realized that the DNR was for R9 and not for R8. V8 said there was a mix up of beds between R8 and R9. V8 said that R8 did not have a wrist band and she had no other way to identify the resident other than what was in the computer. V8 was asked, how do you identify the residents? V8 response was "Name, Date of Birth, Pictures, and social security number." V8 said that she called V2 (Director of Nursing/DON) and told V2 that R9 expired, but called back later and informed V2 that R8 was the person that expired and not R9. V8 said that V2 told her to call 911 and initiate cardiopulmonary resuscitation (CPR). V8 said that V8 did not provide any emergency care to R8 prior to calling V2. V8 said she did not notify the physician of the change in R8's condition. On 11/30/2023 at 3:59 PM, V12 (Certified Nurses Assistance/CNA) said that R8 told her that R9 was having difficulty breathing. V12 said that V8 (Nurse) told her to go and clean R8 up when she has time. V12 said that by the time she could make it to R8's room, the paramedics were already in the room. V12 said that she observed	S9999		

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S9999	Continued From page 4	S9999		

thick yellow mucus coming out of R8's mouth. V12 said that R8's tongue was sticking out, and the resident's mouth was swollen. V12 said that V8 thought that R8 was R9. V12 said that everyone knows who R9 is. V12 said that when V8 realized the mix up 30 minutes after the paramedics had left, V8 rushed to R8's room with the resuscitation cart and initiated cardiopulmonary resuscitation (CPR). V12 said that R8 didn't appear to be breathing at this time because 30 minutes had passed since the paramedics left.

On 11/30/2023 at 09:45 AM, V2 (Director of Nursing/DON) said that the advance directives are in the computer. V2 said that there is a resident profile sheet that hangs at the back of the door which contains the resident code status. V2 said that if the resident has a Do Not Resuscitate (DNR), the DNR form (orange copy) is kept behind the profile sheet that is hanging behind the door. V2 said that this will be the place staff will refer to for residents' code status in an emergency. V2 also said that the facility also tries to keep the same staff on the same unit.

On 11/30/2023 at 1:30 PM, V2 (DON) said that V8 (Nurse) called and notified her that R9 (R8's roommate) had expired and family was notified. V2 said shortly after, V8 called V2 again and informed V2 that it was R8 and not R9 that passed. V2 said that she instructed V8 to call 911 and start CPR. V2 said that V8 originally thought that it was R9 who is a DNR that expired. V2 said everyone knows who R9 is.

On 11/30/2023 at 4:15 PM, V2 said that as a nurse, if a resident is having difficulty breathing, V2 would attend to that resident regardless of code status. V2 also said that residents' photos

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S9999	Continued From page 5	S9999		

are uploaded in the matrix computer system for identification purposes.

On 12/5/2023 at 10:40 AM, V14 (R8's Physician) said that R8 was a full code. V14 said that he was not on call on the day R8 expired. V14 said that V15 was covering for him. V14 said that if he was notified of the change in R8's condition, most likely he would have sent R8 out to the hospital for further evaluation.

On 12/5/2023 at 11:25 AM, V15 (Nurse Practitioner) said that she was on call on the day that R8 expired. V15 said that V8 did not notify V15 about R8's change in condition. V15 said that she would have absolutely sent R8 out to the hospital for evaluation depending on her condition.

On 12/15/2023 at 2:00 PM, V2 said that staff are expected to administer any amount of oxygen to a resident in an emergency if the resident is showing signs of air hunger and notify the physician.

Matteson Fire Department Run Report dated 11/19/2023 at 6:01:00 AM, had R9's name on this run report and documented that I/S was dispatched to a location for the 78 y/o female with difficulty breathing. U/A NH staff at door advised crew the pt. was breathing. Upon making pt. contact in pts. Room pts. Was found sitting up in the bed unresponsive and apneic with a faint carotid pulse. Pt. was placed supine in bed and airway was suctioned by NH staff and cleared of mucus. Pt. was ventilated with BVM. Patient became pulseless and CPR was initiated. Crew asked NH staff if the pt. had a valid DNR. NH staff advised that the pt., has a valid DNR and provided the crew with a paperwork which did not

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S9999	Continued From page 6 include pts. Valid DNR. Crew requested that NH staff locate and provide DNR for crew. CPR was continued by crew. Pt. placed on cardiac monitor with multi-use pads and rhythm check was performed. Pt. was asystole on cardiac monitor and CPR and ventilations were performed. NH staff came back to pt. room and handed crew a copy of the pts. DNR. Crew confirmed that the name on the provided paperwork from the NH staff and the DNR were for the same pt. and the DNR was valid. CPR was stopped by the crew for a rhythm check. Pt. was asystole on the monitor. (Local Hospital) was contacted via cell and pts. death was confirmed by (Doctor) at 0616 hrs. MPD officers were on Scene. Scene was turned over to MPD w/o incident. All times approx. EOR Matteson Fire Department Run Report R8 dated 11/19/2023 documents: In summary, MAI dispatched to above location for CPR in progress. Upon arrival, crew found 76 y/o/f unconscious not breathing with no pulse. Crew notes staff is not performing CPR on patient. Crew member that was directly involved with this patient on previous call states this patient was confirmed deceased by (Local Hospital) ER by alternate EMS crew. Per staff, this patient was pronounced dead with a valid DNR form by previous EMS crew earlier this morning. Staff states that paperwork and identification of patient was mixed up with alternate patient residing in the same room. Nursing home admitted the identification error. Crew took over CPR momentary and when information was gathered, crew discontinued CPR. Contacted (Local Hospital) ER for confirmation of crew's decision to not render deceased patient confirmed by (Doctor). Scene was turned over to Matteson Police. Medical Emergencies	S9999		

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S9999	Continued From page 7	S9999		

Facility Policy:
It is the policy of the facility to provide emergency care to a resident in need of it. Basic life support, including CPR will be provided until the arrival of Emergency Medical personnel in accordance with physician's order and a resident's Advance Directives.

Emergency Care Procedure:

Nurse in charge of resident will evaluate resident's condition. If help is needed and there is more than one nurse available, the nurse assigned to the resident will stay with the resident and will send a nurse's aide to go call the other nurse. The nurse's aide will also bring emergency equipment if needed.

Second nurse will notify DON, resident's physician, and follow his/her orders. Call ambulance, notify family, and fill out transfer form. Call emergency room and let them know resident is on the way.
During extreme emergency, call rescue squad, and call physician and follow above procedures.

If only one nurse available, he/she will instruct one nurse's aide to stay with the resident after the emergency measures have been taken, and the nurse will call physician, or ambulance. Notify family and fill out transfer form.

Documentation of treatment and resident's response during emergency must be done in the clinical record.

Respiratory Distress, Treatment: 3. Check oxygen saturation. Administer oxygen when signs of air hunger are present.

Illinois Department of Public Health

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S9999	Continued From page 8	S9999		

Medical Emergency Response Policy, Objective: 1. It is the policy of the facility to provide each resident with necessary emergency treatment. This includes the facility providing basic life support including CPR, to a resident requiring emergency care until the arrival of Emergency Medical personnel in accordance with physician's orders and resident's Advance Directives. Licensed personnel will assess the resident, determine interventions, notified the resident's physician, and document the event in the medical record.
Procedure: 3. Nursing interventions will include following CPR guidelines, establishing an airway, support breathing and circulation until paramedic assistance arrives, at which time paramedics will direct the care of the resident.

Facility Guidance on Advance Directives, Objective: A resident has a right to make decisions about the health care they receive now and in the future. An advance directive is a written statement prepared by the resident about how these medical decisions are made in the future, if the resident is no longer able to make them for themselves. The residents' choice about advance directives will be respected.
Facility Policy: Change in a Resident's Condition or Status Policy, Objective: Our facility shall promptly notify the resident, his or her attending physician, and representative of change in the resident's condition and/or status. Procedures: 1. The nurse will notify the resident's attending physician or physician extender when: b) There is a significant change in the resident's physical, mental or psychosocial status.

(AA)

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S9999	Continued From page 9	S9999		

2 of 2

300.610a)
300.1210b)
300.1210c)
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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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S9999	Continued From page 10 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. These requirments are not met as evidenced by: Based on interview and record review the facility failed to ensure effective interventions were in place to reduce the risk of falls for 1 of 3 residents (R13) reviewed for safety, this deficiency resulted in R13 falling out of bed on 11/26/2023 and being sent to the local emergency hospital, sustaining an acute intraparenchymal hemorrhage. Findings include: On 12/8/2023 at 2:31pm V22 (Certified Nursing Assistant-CNA) said on 11/26/2023 between 4:00pm and 4:30pm she rounded and observed R13's head on the metal bar underneath the bedside table on the floor. V22 said that it looked like R13 hit her head on the metal bars of the wheels of the bedside table. V22 said that R13 did not have any floor mats at the bedside, and she is a high risk for falls. On 12/13/2023 at 3:45pm, V21(Registered Nurse-RN) said on 11/26/2023 at about 4:30pm, V22 notified her that R13 was on the floor and her head was lying on the metal part of the bedside table. V21 said R13 is a high risk for falls and	S9999		

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S9999	Continued From page 11 assessed her and sent her to the hospital. On 12/14/2023 at 10:35am V2 (Director of Nursing-DON) said that as the fall coordinator if a resident is a high fall risk, she expects all fall interventions to be in place, there should have been fall mats at R13's bedside. R13's resident face sheet indicated that R13 has a diagnosis of Functional quadriplegia, hemiplegia and hemiparesis and cognitive functions. A care plan dated 11/24/2023 with a problem of history of falls and intervention approach to provide resident safety device, floor mats to bilateral sides of the bed. A fall incident report dated 11/26/2023 and a final report dated 11/27/2023 of R13 fall interventions, did not include bilateral fall mats being in place and the report also documents that R13 sustained an acute intraparenchymal hemorrhage. Facility Policy: Reviewed 2/2023 Falls Prevention and Management, Purpose: The purpose of this policy is to support the prevention of falls by implementation of preventive program that promotes the safety of residents based on care processes that represent the best ways we currently know of preventing falls. The falls prevention and management program are designed to assist staff in providing individualized, person-centered care. Fall prevention practices: Care planning and interventions to address fall risk factors: A fall risk care plan will be implemented as part of the baseline care plan to address universal fall precautions and as part of the comprehensive care plan utilizing information from the fall risk	S9999		

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S9999	Continued From page 12	S9999		

assessment. The care plan will be reviewed and revised as least quarterly and with any fall event the resident might experience.

Based on interview and record review the facility failed to ensure effective interventions were in place to reduce the risk of falls for 1 of 3 residents (R13) reviewed for safety, this deficiency resulted in R13 falling out of bed on 11/26/2023 and being sent to the local emergency hospital, sustaining an acute intraparenchymal hemorrhage.

Findings include:

On 12/8/2023 at 2:31pm V22 (Certified Nursing Assistant-CNA) said on 11/26/2023 between 4:00pm and 4:30pm she rounded and observed R13's head on the metal bar underneath the bedside table on the floor. V22 said that it looked like R13 hit her head on the metal bars of the wheels of the bedside table. V22 said that R13 did not have any floor mats at the bedside, and she is a high risk for falls.

On 12/13/2023 at 3:45pm, V21(Registered Nurse-RN) said on 11/26/2023 at about 4:30pm, V22 notified her that R13 was on the floor and her head was lying on the metal part of the bedside table. V21 said R13 is a high risk for falls and assessed her and sent her to the hospital.

On 12/14/2023 at 10:35am V2 (Director of Nursing-DON) said that as the fall coordinator if a resident is a high fall risk, she expects all fall interventions to be in place, there should have been fall mats at R13's bedside.

R13's resident face sheet indicated that R13 has a diagnosis of Functional quadriplegia,

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	IL6000467	A. BUILDING: ______ B. WING ______	C 12/19/2023

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
S9999	Continued From page 13	S9999		

hemiplegia and hemiparesis and cognitive functions. A care plan dated 11/24/2023 with a problem of history of falls and intervention approach to provide resident safety device, floor mats to bilateral sides of the bed. A fall incident report dated 11/26/2023 and a final report dated 11/27/2023 of R13 fall interventions, did not include bilateral fall mats being in place and the report also documents that R13 sustained an acute intraparenchymal hemorrhage.

Facility Policy: Reviewed 2/2023 Falls Prevention and Management, Purpose: The purpose of this policy is to support the prevention of falls by implementation of preventive program that promotes the safety of residents based on care processes that represent the best ways we currently know of preventing falls. The falls prevention and management program are designed to assist staff in providing individualized, person-centered care.

Fall prevention practices: Care planning and interventions to address fall risk factors: A fall risk care plan will be implemented as part of the baseline care plan to address universal fall precautions and as part of the comprehensive care plan utilizing information from the fall risk assessment. The care plan will be reviewed and revised as least quarterly and with any fall event the resident might experience.

(A)