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S 000	Initial Comments Complaint Investigation 2491735/IL170462 2491950/IL170726 2494001/IL173445 Facility Reported Incident of 1/24/24/IL170292 2/24/24/IL170296	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 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 a) Comprehensive Resident Care Plan. A facility,	S9999		

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with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 requirements were not met as evidenced

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by:

Based on observation, interview, and record review the facility failed to ensure that coffee was served at a safe temperature below 140-degrees Fahrenheit (F), failed to ensure a resident was positioned safely while providing direct resident care, and failed to develop fall prevention interventions to include monitoring for a resident with a history of falls, severe cognitive deficits, dementia, and restless agitation. This failure affected 3 of 3 residents (R1, R3, R2) and resulted in R1 spilling coffee sustaining full thickness burns to the right posterior thigh measuring 13.9x6.3x0.1cm (centimeters) and to the left thigh measuring 4.8x18.5x0.1cm. This failure also resulted in R3 rolling out of the bed sustaining a laceration to left eyebrow, subarachnoid hemorrhage, and a nondisplaced patella (knee) fracture.

Findings include:

1) R's latest admit date to the facility is 4/18/24 with a diagnosis of multiple sclerosis. Alzheimer's disease with late onset, major depressive disorder and anxiety.

R1's Minimum Data Set (MDS) dated 12/14/23 documents a brief interview for mental status score of 5/15 which indicates severe impairment. Under section GG functional abilities and goals under eating documents a score of five. Five indicates setup or clean-up assistance- Helper sets up or cleans up. Resident completes activity. Helper assists only prior to or following the activity.

R1's physician progress note dated 1/18/24 documents: R1 is alert with periods of

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forgetfulness. She is able to follow simple commands but with frequent redirection and reorientation. Under psych exam: attention/concentration: attends to tasks with staff assistance, easily distracted; Judgement: impaired; insight: impaired; impulse control: impaired.

Facility reportable dated 2/24/24 documents: R1 was in the dining room for breakfast and activities. After breakfast, R1 attended the activity taking place in the dining room. R1 requested for a cup of coffee from V5 (Activity aide). V5 said she placed a plastic coffee mug with coffee in front of R1 before returning to her tasks. R1 immediately grabbed the mug. Before staff could respond, she spilled the coffee on her lap. Under conclusion: Upon investigation the facility determined that the resident accidentally spilled coffee on herself. Staff responded immediately and provided first aide. Facility has reviewed and ensured all coffee machines are properly calibrated regarding temperatures. Staff was re-educated on assisting residents with hot items.

On 5/22/24 at 10:48AM, V5 said she was preparing an activity in the common dining room when R1 requested coffee. V5 said she got coffee from the machine in the dining room and placed it in front of R1. V5 said she informed R1 the coffee was hot when she placed it on the table. V5 said she went on to continue the activity and heard R1 screaming out, "It burns." V5 said she observed R1 with spilled coffee on R1 and the floor. V5 said R1 threw the coffee cup on the floor. V5 said R1 can be confused at times. V5 said after the incident she was told to let the coffee cool down before giving it to R1 or any residents.

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On 5/23/24 at 1:35PM, V9 (Nurse) was the assigned nurse to R1 on day of the incident. V9 said she did not witness incident but performed a skin assessment after the incident. V9 said R1's skin was red and blistering on both thighs. V9 said R1 is alert to self and has behaviors of throwing items when upset. V9 said she would not give R1 any hot liquids because of her behaviors of being impulsive and the possibility of injury occurring to R1 or other residents or staff.

On 5/23/24 at 2:49PM, V20 (Nurse) said R1 is alert to self. R1 has behaviors of throwing things when upset and it is not a new behavior. V20 said she would not give R1 hot liquids due to this behavior.

R1's progress notes dated 2/24/24 documents: Resident was observed in bed with redness and blistering to bilateral inner thighs. Writer was informed that resident was drinking coffee and spilled it on herself. PCP made aware, orders received and carried out.

R1's wound doctor evaluation dated 2/27/24 documents: Patient spilled hot liquid on inner thighs. Under wound site one documents burn to the right posterior thigh full thickness measuring 13.9x6.3x0.1cm. Thirty percent of skin is fluid filled blister. Under wound site two documents: burn wound of the left thigh full thickness measuring 4.8x18.5x0.1cm

On 5/22/24 at 9:56AM, V7 (Dietary Manager) said coffee should have a temperature of 130-140 degrees F when served. 140 degrees F would be the highest temperature because it may cause a burn. V7 said they check coffee temperatures weekly but do not have a log of the temperatures.

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On 5/28/24 at 1:31PM, V2 (Director of Nurses/DON) said R1 has a history of behaviors of throwing food and yelling out. V2 was asked how do staff determine who is safe to consume hot beverages. V2 said she was not able to answer that question. V2 said staff should wait a few minutes before serving any residents coffee. V2 was asked if the incident with R1 could have been avoided and V2 said probably not based on R1's impulsive behaviors, R1 would of spilled the coffee either way.

Facility hot beverage policy dated 1/16 documents: Facility will ensure that residents are served hot beverages at a temperature that allows palatability while decreasing the risk of inadvertent burns. Hot beverages will include coffee. Dietary staff will take temperature of all hot beverages prior to each meal and record the results on the temperature log for coffee prior to service to resident. The logs will be maintained for one year by the food service supervisor. Those residents determined to be unsafe with hot beverages by the interdisciplinary team will be offered assistance when consuming hot beverages.

2) R3 was diagnosed with generalized muscle weakness and osteoarthritis. Brief interview for mental status dated 05/09/24 documents a score of fourteen which indicated cognitively intact. Section GG (functional abilities) dated 10/28/23 documents: R3 needed partial/moderated assistance (helper does less than half the effort. Helper lifts, hold or support trunk or limb but provides less than half the effort) to roll left and right.

On 5/21/24 at 2:33PM, V4 (Certified Nurses Assistant/CNA) said he was changing R3's linen

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(bed sheet/cover). R3's sheets were wet. R3's linen was half on the bed. V4 said, R3 was on his side but does not recall which side. R3 was not close to the edge. R3 was alert. R3 was able to help turn and reposition. V4 said, before he could walk around to the other side of R3's bed to complete making the bed. R3 fell face down on the floor. R3 sustained a cut above eyebrow which was bleeding. V4 said, he called V6 (Nurse). V6 assessed R3. V4 said, him and V6 got R3 off the floor using a bed sheet. 911 was called. R3 said he was not okay.

On 5/21/24 at 2:49PM, V3 (Assistant Director of Nurses/ADON) said, R3 was alert and oriented times person, place and time. V4 was providing care for R3. R3 required one person physical assist for bed mobility. R3 had a bed support safety rail located on the right side of his bed. R3's right side was his strong side. R3 didn't grab the bed support safety rail when being turned. V4 pulled the draw sheet to assist with turning R3. R3 usually grabs the bed support safety rail to help with turning onto his side when requested. R3 rolled out of the bed onto the floor. R3 sustained a laceration to the left eye and knee. R3 was diagnosed with a subdural hematoma and left knee fracture.

On 5/21/24 at 3:04PM, V3 said, the bed support safety rail is used to aide with bed mobility. Verbal cues were given to R3 to remind R3 to grab the bed support safety rail. R3 only needs prompting. V4 informed R3, that they were going to turn. R3 was awake but could have still been a little sleepy. V4 should have made sure R3 grabbed the bed support safety rail before proceeding to the next step of turning.

On 5/21/24 at 3:10PM, V6 (Nurse) said, R3 was

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being changed by V4. R3 has a habit of not cooperating and being stiff. It might take a minute for R3 to relax his body. R3 may cooperate but on occasions additional staff is needed. V4 told R3 to turn on his side, which R3 can do with help. R3 was seen on the floor. R3 was on his left side facing his bed. R3 hit his forehead on the wheel of the bed. R3 complained of knee and back pain. R3 said he fell, he couldn't believe it and he was dazed.

On 5/21/24 at 3:52PM, surveyor observed a bed support safety rail on the left upper side of R3's bed. R3 was assessed to be alert and oriented to person, place, and time. R3 said he was half asleep while being changed by V4. It was a routine activities of daily living (ADL) care. R3 said he was too close to the edge of the bed. R3 said, V4 pushed him to the right side resulting in a fall onto the floor. R3 said, at the time of the incident, he did not have a bed support safety rail on the right side. R3 said, he was holding the mattress. There was nothing else to hold on to. There were no floor mats on the floor. R3 said, his left side/left upper extremity was weaker than the right. R3 said, he did not have anything to assist him when he was turning on his right side. R3 said, V4 pushed him and he ended up on the floor.

On 5/23/24 at 12:40PM, V17 (Physical Therapy Assistant) said R3 has a bed support safety rail on the left side of his bed. R3 did not have a bed support safety rail on the right. R3 has bilateral weakness to the upper extremities. A bed support safety rail is used for poor trunk control. It aides with turning right or left. R3's bed support safety rail on the left side can only assist with turning towards the left side.

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Nursing note dated 01/24/2024 documents: Writer called to resident room by CNA (V4) status post (s/p) witnessed fall, resident (R3) observed on floor, vitals performed, and neuro check performed. Resident assisted by two staff back to bed. Noted left brow bleeding, bruising and lacerations to left knee. 911 called.

Facility fall occurrence dated 01/24/24 documents: General Information: Fall, Cognition prior to occurrence: oriented times two, Injuries: Laceration to left brow. Laceration and bruising to left knee. Notes: CNA was performing AM care and was rolling the resident to the side in order to change the bed sheets. When the CNA pulled the sheet to make the bed while resident was on his side, the resident rolled off the bed. Fall type: Falling to ground. Laying on right side, mattress on the floor: no.

Facility final reportable incident dated 01/29/24 documents: V4 stated that he was providing ADL care to the resident (R3), during which he instructed the resident to turn to his right side. V4 states, that the resident has a bed support safety rail on the right side of his bed for mobility but did not grab it. V4 states that the resident turned with more force that normal and fell out of the bed at approximately 5:30AM.

Hospital paperwork dated 1/24/24 document: Patient (R3) presented to the emergency department for evaluation of head injury after mechanical fall. Per emergency medical service (EMS), patient was turning in bed when he fell out of bed. Patient fell with head strike hitting the left portion of his forehead on the ground. Patient complained of left-sided knee pain (multiple abrasions noted to the left knee), left shoulder pain and pain associated with facial laceration to

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the left eyebrow (with bleeding) measuring four centimeters in length and depth requiring five sutures. CT (computed tomography scan) of the head demonstrated subarachnoid hemorrhage near the right frontal lobe. Left knee x-ray: Nondisplaced patella fracture. Patient placed in left-sided knee immobilizer.

3) R2 was diagnosed with Dementia with behavior disturbance, restlessness, agitation, weakness and generalized anxiety. Hospice referral package dated 2/19/24 documents: Family was looking for respite care 2/28/24 - 3/8/24. R2 has a history of falls. R2 has had three falls since admission. R2 needs standby assist with transfers. R2 continues to have progressive weakness. R2 does not ambulate at most times and the seat of the roller walker is used to move her about the home.

On 5/22/24 at 12:34PM, V12 (Nurse) said, R2 had behavior issues. R2 attempted to get out of the chair and bed. Medications and distractions were not working. R2 would scoot to the end of her chair or sit sideways, putting legs over the chair arm and get out of the chair on her knees. R2 was able to move body and climb.

On 5/22/24 at 1:50PM, V3 (ADON) said, R2 kept trying to get out bed on to the floor. R2 had a fall upon admission. The second incident was not a fall, R2 was on the floor in a praying position. R2 got herself out of the bed to pray.

On 5/22/24 at 2:40PM, V45 (CNA) said, R2 was in a room away from the nursing station then she was moved across from the nursing station.

Nursing note dated 2/28/24 documents: writer observed resident sitting on floor near bed.

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Nursing note dated 3/5/25 documents: resident (R2) climbed out of chair and sat on floor in a praying position.

Fall report dated 2/28/24 documents: R2 was alert to self. BIMS (Brief Interview for Mental Status) 4 (severe cognitive impairment). Visually observed on the floor near bed, sitting on buttock. R2 demonstrated poor safety awareness and was unable to be redirected. R2 also had wandering behaviors with an unsteady gait.

R2's fall care plan dated 2/28/24 documents: Resident has history of falling related to weakness, unsteady gait, and cognition. Interventions dated 2/28/24: Place resident in a fall prevention program; Provide resident an environment free of clutter; Keep call light in reach at all times. Intervention dated 3/29/24: Observe frequently and place in supervised area when out of bed.

Falls prevention and management policy revised 2/2023 documents: The purpose of this policy is to suppose the prevention of fall by implementation of a preventive program that promotes the safety of residents based on care processed that represent the best way we currently know of preventing falls. The fall prevention and management program is designed to assist staff in providing individualized person-centered care. Fall refers to unintentionally coming to rest on the found, (sic) floor or other lower level. A fall without injury is still a fall. When a resident is found on the floor, a fall is considered to have occurred.
(A)
Statement of Licensure Violations (2 of 2)

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300.610a)
300.1210a)
300.1210b)

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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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.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide feeding assistance for residents with visual deficits that were identified as needing assistance which resulted in an unplanned serve weight loss. This affected two of three residents (R8, R9) reviewed for unplanned weight loss. This failure resulted in R8 having a weight loss of 8.99% in one month and R9 having a weight loss of 10.6% in four months.

Findings Include:

1) R8 has a diagnosis with Dementia.

On 05/24/24 at 12:21PM and 12:33PM, R8 was observed with her head tilted to the ceiling with a non-focusing blank stare while eating in the dining room with no feeding assistance. R8 was observed scooping pureed food off her plate onto the tray, putting the spoon in her mouth with no food on it. R8 dropped the spoon on the tray. R8 was observed tapping around on the tray with her hand, putting her fingers in food then licking food off her fingers for twelve minutes until she touched the spoon and preceded to feed self with

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	IL6000467	A. BUILDING: _____ B. WING _____	C 05/30/2024

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		

small amounts of food.

On 05/24/24 at 12:51PM, V3 (Assistant Director of Nurses) said, R8 required set up assistance only. R8 refuses help with feeding assistance. R8 has vision impairment. R8 was asked by the surveyor, if she would like some help with eating. R8 nodded head up and down in a yes motion. V3 said, R8 nodded head in a yes motion. V3 assisted feeding R8. R8 took two small portions of food from the tip of the spoon.

On 5/24/24 at 2:30PM, V2 (Director of Nurses) said, R8 has had weight loss in last six months. V2 said, she expects staff to assist with feeding for R8 as recommended by the dietitian.

Care plan dated 9/26/23 documents: R8 is alert with confusion and exhibits impaired cognitive functioning status. R8 is unable to visually track objects or people. Receive mechanically altered diet with puree meat and vegetables related to edentulous (no teeth): approach 1:1 feeding assist.

R8's dietary note dated 05/08/2024 documents: weight: 79 pounds, down 9% and 10.9% x 1 and 6 months respectively. This is the lowest weight recorded over the past six months of reviewed data. Diet order dated 05/08/2024 documents: Patient (R8) must be fed by staff. Will need to continue to encourage by mouth intake at all meals. Recommendation: give much encouragement to eat.

R8's vital report documents: May: 79 lbs (pounds), April: 86.8 lbs, March: 87.8 lbs, February: 84.6 lbs and January: 91 lbs.

Facility weight maintenance policy revised 03/22

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documents: It is the policy of this facility to monitor the nutritional status of all residents, including all the significant or trending patterns of weight change to maintain acceptable parameters of nutritional status. All significant, unplanned, or trending weight changes must be investigated by the facility. Suggested parameters for evaluating significance of unplanned and weight loss are: interval one month, significant loss of 5% or severe loss of greater than 5%; interval three months significant loss of 7.5% percent or severe loss of greater than 7.5%; interval six months significant loss of 10% percent or severe loss of greater than 10%. In the case of a significant weight or trending weight change the following steps will be taken; determine the possible cause; determine plan of action; notify the physician and responsible party.

2) R9 has a diagnosis of Dementia, Glaucoma, Intraocular Lens (tiny artificial lens for eye) and Multiple sclerosis. Brief interview for mental status dated 4/4/24 documents a score of fourteen which indicates cognitively intact.

On 5/24/24 at 12:56PM, R9 was observed with a lunch tray on the bed side table directly in front of R9. R9 was trying to feed herself string beans with a spoon that she held backwards in her hand. R9 who was assessed to be alerted and oriented to person, place and time, said I can't feed myself.

On 5/24/24 at 1:06PM and 1:15PM, While surveyors were observing R9's room, V34 (Guest Services-Certified Nurses Assistant/CNA) went into R9's room to assist with feeding R9. V34 said, she had never fed R9 before and she was just helping out. R9 said, V34 has never fed her

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before and she does not receive feeding assistance from any staff. V34 stop feeding R9. V34 said, R9 didn't eat much.

On 5/24/24 at 1:50PM, V26 (Occupational Therapist/OT) said, R9 needs assistance with meals due to visual impairment and impaired coordination related to multiple sclerosis. V28 (OT) said, R9 was having difficulty getting food in her mouth. R9's coordination has gotten worst.

On 5/24/24 at 2:30PM, V2 (DON) said, R9 is not on a weight loss program.

Care plan edited 04/05/2024 documents: R9 requires assist with ADL's (activities of daily living) related to weakness, lack coordination and impaired mobility in regards to multiple sclerosis. Approach dated (7/7/2020) documents: R9 can eat in room and be monitored from hallway during rounds, (edited 1/11/24) documents: eating: supervision and set up help.

R9's vital report dated 01/2024 - 05/2024 documents: May 179.8 pounds (lbs), April 186 lbs, March 187 lbs and January 198 lbs.

Physician note dated 4/25/24 documents: R9 reports good appetite.

Dietary note dated 5/8/24 documents: weight (WT): 180 pounds, down 11.2% x 6 months. Weight decline each month noted since 3/4. By mouth (po) intake does not appear to be meeting needs for weight maintenance. Some slow/steady weight decline may be beneficial as patient has a high body mass index (bmi) 29.9, however rapid loss is not desired.

Facility weight maintenance policy revised 03/22

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