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 _____	06/28/2024

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

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S 000	Initial Comments Annual Licensure Survey Complaint Investigation 2494376/IL173949	S 000		
S9999	Final Observations Statement of Licensure Violations: 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, 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	S9999		

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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 regulations were not met as evidenced by:
Based on observation, interview, and record review the facility failed to implement and ensure effective interventions were in place to reduce the risk of falls/falls with injury for three of three residents (R58, R69 and R80) in the sample of 22

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reviewed for fall prevention program.

Findings include:

1. On 6/26/2024 at 9:40am R80 was observed in bed with one floor mat on the right side of the bed only.

On 6/26/2024 9:45am V13 (Licensed Practical Nurse-LPN) observed with surveyor R80 with one floor mat and said R80 is a high fall risk and should have two floor mats, one each side of the bed.

On 6/26/2024 at 10:10am V2 (Director of Nursing-DON) said R80 is a high fall risk and should always have bilateral floor mats down while in bed.

A face sheet indicated R80 was admitted to the facility on 3/12/2024 and has a diagnosis of repeated falls, syncope and collapse. An initial fall risk assessment dated, 3/12/2024 had a score of 7 that indicated R80 was low risk. Admission care-plan dated 3/13/2024 problem: History of falls. On 3/13/2024 a BIMS (Brief interview of Mental status) score was documented of 99-no resident was unable to complete interview.

On 3/13/2024 a fall intervention was put in place, bed in a low position while in bed.

On 3/17/2024 R80 had a fall, complained of hitting the back of his head and right wrist pain. An intervention of bilateral floor mats while in bed was put in place.

On 3/23/2024 R80 had an unwitnessed fall and complained of left shoulder pain, an intervention of bed bolsters was put in place.

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S9999	Continued From page 3 On 4/5/2024 R80 was found on the floor with wheelchair turned over. No fall intervention was in place. On 4/14/2024 R80 had an unwitnessed fall, found lying on the floor next to his bed on his left side. R80 was unable to verbalize what happened. No fall intervention was put in place. On 4/14/2024 an x-ray of left humerus anatomic neck and multiple left ribs were observed. A portable x-ray dated on 4/26/2024 for pain and guarding, indicates R80 sustained a faint lucent line across the neck of the left femur, a subtle shortening of the femoral neck noted. Impression acute nondisplaced left intertrochanteric femur fracture. On 5/20/2024, most recent, R80 had a BIMS-score 99-no resident unable to complete interview. A physician order sheet dated 5/27/2024, no fall orders. On 5/29/2024 R80 had a fall, was observed on the floor in front of his wheelchair. R80 said he slid out of his wheelchair and was observed guarding his left lower extremity near his hip. No fall intervention was put in place. On 6/12/2024 R80 was observed on the floor in a laying position next to bed, could not verbalize what happened. A fall intervention was put in place for a safety appliance to elevate heel while in bed with a cushion. 2. On 6/26/24 at 10:48AM, With V14 Registered	S9999		

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Nurse (Registered Nurse-RN) R69 was observed in bed in semi-fowler's position leaning to the right side of the bed with her head hanging from the bed. V14 repositioned R69. R69 is alert and responsive but confused. No floor mat on the right side of the bed, only on the left side. R69's bed is not in the lowest position. V14 took the bed control on top of bedside drawer and placed R69's bed in the lowest position. V14 said that R69 is at high risk for falls. R69 should have a floor mat on both sides of the bed and the bed should be in the lowest position when in bed. V17 (Certified Nurse Assistant-CNA) said that she is the assigned CNA for R69. V17 said that she received R69 with only one floor mat on the left side of the bed when she came to work this morning. V17 said that R69 should have a floor mat on both sides of the bed and R69's bed should be in the lowest position.

On 6/26/24 at 10:55AM, Informed V4 (Assistant Director of Nursing-ADON) of above observation. V4 said that R69 should have bilateral floor mats on each side of the bed and the bed should be in the lowest position while in bed.

On 6/26/24 at 12:30PM, Informed V2 (DON) of above observation. V2 said that R69 is at risk for falls. She should have a floor mat on both sides of the bed and the bed should be in the lowest position while in bed. V2 added that they should implement fall preventive interventions in place.

R69 is re-admitted on 3/12/24 with a diagnosis listed in part but not limited to repeated falls, history of falling, abnormalities of gait and mobility, unsteadiness of feet, muscle wasting and atrophy, osteoarthritis. Fall assessment done on 4/20/24 indicated she is at high risk for falls. Fall care plan indicated that she is at risk for falls

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related to impaired cognitive status, impaired functional status, weakness/deconditioning cellulitis of left lower limb. Intervention: Keep bed in lowest position with brakes locked.

3. On 6/26/24 at 11:56AM, R58 was observed with V10 (Concierge/CNA unit manager) lying in bed not in lowest position with only 1 floor mat on right side of the bed. V10 took the bed control located on top of his bedside drawer and placed R58's bed in the lowest position. V10 said that R58's should have bilateral floor mats on each side of the bed and bed should be in the lowest position when resident is in bed.

On 6/26/24 at 12:30PM, Informed V2 (DON) of above observation. V2 said that R58 is at risk for falls and on a fall prevention program. He should have floor mats on both sides of the bed and the bed should be in the lowest position while in bed. V2 added that they should implement fall preventive interventions in place.

R58 is re-admitted on 2/1/24 with diagnosis listed in part but not limited to history of falling, cognitive communication deficit, muscle weakness, osteoarthritis. Fall assessment done on 4/16/24 indicated he is at high risk for falls. R58's fall care plan indicates that he is at risk for falls related to difficulty with balance and gait, dependent on assistive device for locomotion, requires assist for toileting, use of medications that can cause weakness or lethargy, history of falls, and diagnosis including cardiac, vision impairment, incontinence, acute and chronic medication conditions. Interventions: Provide resident with safety device/appliance: Bilateral floor mats when in bed. Fall prevention program protocol. Keep bed in low position with brakes locked.

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S9999	Continued From page 6 Facility Policy: Fall Prevention and Management revised 2/2023 Purpose: The purpose of this policy is to support the prevention of falls by implementation of a 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. The falls prevention and management program provide a framework and tools to identify and communicate about a resident's risk for fall. Additionally, the program addresses a safe process to follow for supporting a resident who has experienced a fall event. Fall prevention Practices: Fall prevention and management practices include separate activities. . universal fall precautions Universal fall precaution: . universal fall precautions are safety measures that are taken to reduce the chance of falls for all residents regardless of individual fall risks. (B)	S9999		