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 12/18/2024

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 Complaint Investigations: 2499968/IL182096 2499325/IL180900	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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	S9999		

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 interview and record review the facility failed to perform a safe transfer by not using the mechanical lift for 1 resident (R2) dependent on staff for transfers. This failure affected one of three residents reviewed for injury. This failure resulted in R2 sustaining an acute mildly displaced fracture of the distal femoral diaphysis on the left leg.

This past non-compliance occurred from 11/7/24 to 12/4/24.

The findings include:

The facility reported to IDPH (Illinois Department

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of Public Health) that on 11/7/24 while R2 was being transferred to dialysis chair by CNA (Certified Nurses Assistant), R2 slid down and had an assisted fall. Shortly after, R2 complained of pain to left knee. Small bump noted to left knee. R2 sent to the hospital for evaluation. Imaging received from the hospital identified distal femur fracture.

R2's diagnosis include but are not limited to Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 5 Chronic Kidney Disease, Atherosclerosis of Native Arteries of Left Leg with Ulceration of Other Part of Foot, Peripheral Vascular Disease, Anxiety Disorder, Depression, Polyneuropathy, Fracture of Lower End of Left Femur, Dependence on Renal Dialysis, and Weakness. Physical Therapy record includes diagnosis of Right Above the Knee Amputation.
General Order dated 8/8/24 for R2 notes transfers: mechanical lift x 2 assist.

On 12/12/24 at 12:00PM R2 said the day I fell I asked V9, Certified Nursing Assistant (CNA), for the mechanical lift and the dialysis chair. R2 said V9 said there was no time for that. R2 said V9 said I am not walking all the way down the hall to dialysis to get the chair. R2 said I fell as V9 and some other aid were transferring me into the chair in the dialysis room. R2 said I fell onto my knee, and it hurt. R2 said I told them I needed to go to the hospital. R2 said I went to the hospital, and I have a fracture. R2 said I did not get dialysis on that day. R2 said before the fall staff were not always using 2 people to transfer me. The surveyor observed R2 has left leg and old/healed right leg amputation. A lift pad was observed hanging on the back of R2's door.

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On 12/13/24 at 9:52AM V9 said I had taken care of R2 before. V9 said I got R2 ready, meaning I got her dressed for dialysis and gave patient care. V9 said I put a clean gown on her. V9 said I didn't have the proper stuff to work with R2 on that day. V9 said I got help from another CNA and put R2 in a wheelchair by lifting her in. V9 said we have done mechanical lift and manual lift transfers with R2. V9 said R2 don't stand at all, we have to completely lift R2. V9 said R2 didn't say anything about the transfer. V9 said this was not the first time R2 didn't have a lift pad in the room. V9 said if there is not a lift pad, then we are supposed to look for one. V9 said we couldn't find one. V9 said pads are hanging on the mechanical lift or they have they their own in the room. V9 said they (the facility) don't have a stock of pads. V9 said we took R2 to dialysis around 6:15-6:40AM. V9 said in the dialysis room as we were taking R2 out of the wheelchair "she got twitching and wiggly". V9 said R2 was lowered to the floor. V9 said another aid helped me, I don't know her name.

On 12/13/24 at 10:27AM V10, CNA, said a CNA was passing me by and asked me to help her. V10 said I didn't know R2. V10 said when we got to dialysis, I saw R2 had 1 leg. V10 said we tried to lift R2 into the chair and R2 could not hold herself up and we lowered R2 to the ground. V10 said in lowering her, R2 bent her leg. V10 said I never worked with R2 and didn't know she required a mechanical lift.

On 12/12/24 at 1:14PM V2, Licensed Practical Nurse/LPN, said I wasn't there for R2's fall. V2 said I heard they needed help and came on the dialysis unit. V2 said I saw R2 was on the floor, she was crying out noises, sort of pain. V2 said we got her up and into a dialysis chair. V2 said

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R2 said she wanted to go to the hospital. V2 said R2's knee was visible. V2 said R2 expressed pain and according to the statement I looked and she may have had a bump. (The surveyor provided V2 with her witness statement during the interview.)

On 12/13/24 V12, Restorative Nurse, said the staff have a sheet that tells them what level of assistance a resident requires. V12 said on admission I see the patient and identify the transfer status for them. V12 said on the care plan and resident profile sheet I include level of transfer assist needed for the resident. V12 said on hire I tell staff about the transfer status. V12 said R2 has been a mechanical lift since July 2024. V12 said on assessment R2 was weak and not able to use 2 person lift due to pain and shortness of breath. V12 said on 11/7/24 R2 was identified to require a full body mechanical lift. V12 said R2 usually has a lift pad hanging behind the door. V12 said when I spoke to R2 she said she asked the CNA to use the lift. V12 said the cause of the fall was that the staff did not use the lift to transfer R2. V12 said I have not received reports of lift pads or lifts not available for resident transfer. V12 said the lift pads are kept in the room behind the door, in the laundry room, and in my office. V12 said if I am not here the unit 3 nurse has the key to my office, so they can get a lift pad. V12 said R2 is alert. V12 said the practice to get a patient up for dialysis is to obtain the weight before getting out of mechanical lift. V12 said we have 3 full body mechanical lifts. V12 said the practice is to get the wheeled dialysis chair to the resident room, use the lift pad to transfer with the mechanical lift and place the residents into the dialysis chair and then bring the resident in the chair to the dialysis room. V12 said we usually don't place the resident into a regular

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wheelchair when preparing for dialysis. V12 said the staff needs to get the chair from dialysis. V12 said R2 did not have her prosthesis on the day of the fall, it is not even in the room.

On 12/13/24 at 11:51AM V6, Assistant Director of Nursing, said I called the hospital to follow up on R2 and I was notified she had a fracture. V6 said R2 returned and she had the immobilizer on to her left leg. V6 said I started my investigation by asking R2 and the CNA what happened. R2 said while being transferred she slid and her left leg was unable to hold her body weight and she slid forward. V6 said the staff performed an improper transfer, R2 was supposed to be transferred with a mechanical lift. V6 said V9 transferred R2 with assistance from V15, CNA, from her bed into a wheelchair in her room. V9 then took R2 to dialysis room. V6 said then V9 attempted a second transfer to get R2 into the dialysis chair with assistance from V10. V6 said R2 was new to both V10 and V15. V6 said V9 performed two improper transfers with R2. V6 said the transfer procedure for R2 should have been to bring the dialysis chair to the room and then wheel R2 to dialysis in the chair. V6 said at dialysis the mechanical lift can be brought into the room and used to assist the resident into the chair. V6 said V9 said that R2 did not tell her that there was a lift pad in the room. V6 said V9 said she has gotten R2 up in the past without the use of the mechanical lift. V6 said R2 was working with therapy, but we had not gotten the ok from therapy to discontinue the mechanical lift. V6 said for the improper transfer I gave V9 disciplinary actions. V6 said V9 claimed there were no lift pads. V6 said each resident has 2 lift pads in the room, 1 for use and an extra one if soiled. V9 said if there is no lift pad, then the staff should look for another lift pad, if not found then they

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should notify the on call person that no lift pad can be found. V6 said I was not notified that they could not find a lift pad before the incident. V6 said R2 said she told V9 the pad was there. V6 was asked asked if the CNA should make the decision to not use a lift for transfers. V6 replied "no". V6 said R2 has not had previous falls. V6 said R2 had an order in the old computer system (facility began a new electronic charting system in November 2024) stating she was a two person transfer with mechanical lift. V6 said the order was not discontinued.

R2's MDS (Minimum Data Set) assessment for Cognitive Patterns Assessment dated 10/21/24 notes a score of 15, intact. MDS Functional Ability assessment for R2 dated 10/21/24 documents impairments to range of motion to both sides of lower extremity. R2 is documented dependent on staff for toileting hygiene, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Dependent- helper does all of the effort. Resident does none of the effort to complete the activity.

Functional Abilities Assessment dated 10/29/24 identifies R2 is dependent for transfers. Restorative Assessment dated 10/29/24 identifies R2 is dependent for transfers. R2 is non-weight bearing. R2 uses no splint, braces, or prostheses. R2's Fall Risk Assessment identifies R2 is at high risk for falls.

Order Summary Report notes R2 has dialysis ordered Tuesday, Thursday, and Saturday. Incident occurred on 11/7/24, Thursday. Order Summary Report includes an order dated 11/13/24 for immobilizer to left knee at all times. R2's hospital record dated 11/7/24 CT of left knee findings states comminuted, mildly displaced fracture of the distal femoral diaphysis. Small

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knee joint effusion and mild surrounding soft tissue edema. X-ray of the left knee dated 11/7/24 states acute mildly displaced fracture of the distal femoral diaphysis.

R2's hospital orthopedic consult dated 11/7/24 states she was being transferred to her dialysis chair and was accidentally dropped by a staff member, she reports her leg was bent back and was very painful. She complains of pain in the left knee, left ankle and has spasms going down her left leg. States she does not walk and has not walked in two years. She uses a mechanical lift for transfers and does not put weight through her left leg. Plan includes R2 is a poor surgical candidate due to bone quality and medical history.

The facility did not provide a seperate incident/accident report than the facility IDPH reportable.

The facility Limited Lift / Resident Handling policy dated 5/17 states It is the intention of this facility to provide safest environment as possible for our residents. Residents are assessed periodically for safety in transferring. Staff will use safety devices to assist in the transferring of our residents that have been assessed that the resident is no longer safe to be independent in this area. These devices may include gait belts and mechanical lifts.

The facility Mechanical Lift policy dated 2/17 states A mechanical lift assist staff to lift and move a resident as safely and as easily as possible.

Prior to the survey date of 12/18/24, the facility had taken the following action to correct the

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S9999	Continued From page 8 noncompliance: 1. Inservices for safer transfers began at the facility on 11/7/24-11/9/24. More inservices done 11/21/24 and 12/4/24. 2. Competency by return demonstration of safe transfer training. 3. Safe transfer audits are being completed, started 11/15/24; 11/16/24; 11/19; 11/25; 11/26; 12/3; 12/5 ...and is ongoing during my survey. 4. QA meeting held 11/19 with administrator, DON, and medical director to discuss improvement plan. 5. Interviews with staff regarding transfer status knowledge. I have no concerns. 6. DON said there was 90% staff training completed on initial inservicing. As of Friday 12/13/24, there were 4 CNAs left to train. They are PRN (as needed) staff. 7. The CNA who performed the improper transfer had not returned to work because she refused to come to the facility for training. Observation of transfers during the survey completed, no concerns. Observation of mechanical lift pad equipment available to staff. (A)	S9999		