STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006837	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS OAKTON PAVILLION	1660 OAKTON PLACE DES PLAINES, IL 60018

(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 Survey 2590577/IL185029	S 000		
S9999	Final Observations State Licensure Violations: 300.1210a) 300.1210b) 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) 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.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their policy and procedure for hydration and tube feeding tube care by not ensuring that a resident received the recommended amount of fluids for a resident who is dependent on tube feeding for nutrition. This failure applied to one (R1) of four residents reviewed for hydration and resulted in R1 being hospitalized with diagnoses including dehydration, high blood sodium, and hypotension (low blood pressure).

Findings include:

R1 is a 42-year-old male with a diagnoses history present on admission of Brain Damage due to Oxygen Deprivation, Bacterial Infection, Epilepsy, Congestive Heart Failure, Stage 4 Pressure Ulcers, Acute Kidney Failure, UTI's, Trach Use, and Feeding Tube Use who was admitted to the facility 07/27/2024.

On 02/10/2025 at 10:29 AM Observed R1 in his room lying in his bed unable to speak, bed bound, and receiving a enteral nutrition via a tube feeding.

R1's current care plan documents he has potential for impaired nutrition related to acute and chronic medical conditions, wound, being tube feeding dependent, and receives nothing by mouth with interventions including; registered dietitian to provide monthly nutrition assessment and evaluate fluid needs and

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adequacy/appropriateness of current feeding regimen, and report any early signs of fluid overload or dehydration to the physician for further medical evaluation.

R1's Monthly Enteral/Skin Note created by V9 (Registered Dietitian) dated 11/01/2024 documents R1 was being readmitted from a hospitalization and was receiving an enteral flush of 30ml of every 4 hours with recommendations to increase his flush back to 200ml every four hours the new flush would provide 2297 ml of fluid.

R1's physician order history includes an order effective from 10/31/2024 to 12/02/2024 for flushing his feeding tube with 30ml and of water every four hours.

R1's November and December 2024 Medication Administration Records documents he was receiving a flush with 30ml of water every four hours from 10/31/2024 to 12/02/2024.

R1's progress note dated 12/2/2024 08:02 Writer spoke with a Registered Nurse at the hospital and was notified that the resident's blood pressure remains severely low, and resident is dehydrated.

R1's hospital record dated 12/02/2024 documents he was admitted to the emergency room from the nursing home due to significant hypotension, was evaluated and received a primary diagnosis of dehydration, and of high blood sodium and chloride and acute kidney injury; he was assessed on admission to be profoundly dehydrated with an acute renal insufficiency and high blood sodium and it was noted that he was likely hypotensive related to these diagnoses.

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S9999	Continued From page 3 02/13/2024 at 1:12 PM V2 (Director of Nursing) reported that on admission there is a section of the admission assessment that addresses nutrition and the RD (Registered Dietitian), Nurse Practitioner, Physician's Assistant, and Physician are made aware of residents enteral feeding orders received from the hospital and the orders are reconciled on admission. V2 reported the RD then further evaluates the resident's needs, makes recommendations for changes to formula, volume and flushes, and labs are also ordered on admission and readmission. V2 reported labs are ordered and evaluated by the RD, Nurse Practitioner, Physician's Assistant, and Physician and the facility uses pumps for enteral feedings and flushes and these are to be signed off on Medication Administration Records. V2 reported a collaboration of nurses assessments, weights, labs, and RD/Nurse Practitioner/Physician evaluations and recommendations are used. 02/13/2024 at 2:23 PM V2 (Director of Nursing) stated after the RD (Registered Dietitian) makes a recommendation the nurses are to call the physician to see if they agree with the orders and the orders are changed if the physician agrees. V2 stated typically the RDs will put in orders if they change the actual feeding, and the nurses verify the orders so there is a two-step process. V2 stated once the nurse confirms the orders and the orders they are verified in the resident's medical chart under physician orders. V2 stated if a flushing order was needed for R1, and it was not entered it could affect his electrolytes and his hydration. V2 stated if R1 was not receiving enough fluids and the RD recommended an increase in flushes this could possibly cause dehydration because his urine output might decrease. V2 stated fluid intake for R1 is monitored by observing feeding tube flushes and	S9999		

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how many cc's (cubic centimeters) of fluid he receives an hour through enteral feeding and his fluid output is monitored by observing whether there is a decrease in how many times he receives incontinence care, whether there is a urine odor, or if incontinence products used may become discolored because of urine concentration.

R1's progress notes from 11/01/2024 - 12/02/2024 did not include any communication with his physician regarding V9's (Registered Dietitian) recommendations to increase his fluids as documented in her notes on 11/01/2024.

02/13/2024 at 4:10 PM V2 (Director of Nursing) stated V9 (Registered Dietitian) never submitted an order for R1's recommended fluid increase. V2 stated V9's progress note regarding this recommendation was originally entered into an inactive electronic health record system on 11/04/2024 and the note was never transferred to the electronic health record system that became actively used on 11/01/2024. V2 stated the facility was not aware of or notified of V9's recommendations to increase his fluids until 12/03/2024 when V9 provided this recommendation by email. V2 stated the facility reviewed Medication Administration Records for 24 hours after the transition of the electronic medical record system on 11/01/2024 however there was no order submitted by V9 for R1's fluid increase. V2 stated it was V9's responsibility to ensure the facility received the recommendation or order to increase R1s fluids and she should have communicated this information in real time. V2 stated the concern with V9's failure to ensure the recommendation was communicated or ordered is that R1 was not getting the amount of fluids he needed. V2 stated the physician was

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S9999	Continued From page 5 never notified of V9's recommendation to increase R1's fluids due to the missing communication from V9. The facility's Tube Feedings/Enteral Nutrition Policy received 02/11/2025 states: "Objectives: to maintain the desired fluid status of a resident." (A)	S9999		