PRINTED: 06/10/2025 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. Bollebino.			
		IL6007793	B. WING		04/1	1/2025
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GENERA	TIONS AT REGENCY	6631 MILV NILES, IL	VAUKEE AVI 60714	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure a	nd Certification:				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations (1 of 2)				
	300.610a) 300.1210b) 300.1210d)2)					
	Section 300.610 Re	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory coof nursing and othe policies shall comp	shall have written policies and ng all services provided by the policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the ommittee, and representatives in services in the facility. The ly with the Act and this Part.				
	Section 300.1210 O Nursing and Person	General Requirements for nal Care				
	care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of resident to meet the care needs of the re-					
	d) Pursuant to	subsection (a), general				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/02/25 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 9 VN6011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007793	B. WING		04/	11/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GENERA	ATIONS AT REGENCY		WAUKEE AVE	ENUE		
	OLIMANA DV OTA	NILES, IL		PROMPERIO PLANTOS CORRE	OTION	4.4-5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
		nclude, at a minimum, the be practiced on a 24-hour, basis:				
		its and procedures shall be dered by the physician.				
	These regulations v	vere not met as evidence by:				
	review, the facility fa an indwelling cathet not preventing a uri three residents (R1)	on, interview and record ailed to monitor a resident with ter and follow their policy by nary tract infection for one of 53) reviewed with urinary are resulted in R153 having a on.				
	Findings Include:					
	4/3/25 documents a indicates cognitively with urinary retention	ew for mental status dated a score of thirteen which y intact. R153 was diagnosis on. Minimal data set section H) dated 4/7/25 documents:				
	an indwelling cather had thick white par inner lining and floa tube. R153 was also R153 who was asset to person, place and catheter but was undate her indwelling. On 4/8/25 at 11:20a	am, R153 was observed with the dated 3/29. R153 catheter tials/sediments stuck to the ting inside of her catheter to observed with cloudy urine. The essed to be alert and oriented the said, staff changes her table to report exactly what catheter was last changed. The essential staff changes her table to report exactly what catheter was last changed. The essential staff changes her table to report exactly what catheter was last changed.				

Illinois Department of Public Health

STATE FORM 6899 VN6011 If continuation sheet 2 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
		IL6007793	B. WING		04/	11/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GENERATIONS AT REGENCY 6631 MILV NILES, IL		WAUKEE AV 60714	ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
\$9999	tube/bag with cloud said, R153's indwel been change prior to Physician order dat Urinalysis (UA)/ Uri Nursing note dated analysis flagged for R153's laboratory respecimen Collectio Urinalysis: Clarity: (Clear) Blood: Small Negative), Leukocy Range: Negative), Eange: None) On 4/10/25 at 11:28 said, R153 has a urstarted on antibiotic seen R153's indwel updated the doctor Nurse practitioner produments: Abnormatine yesterday. Physician Order day Augmentin Oral Tat Pot Clavulanate) Gieight hours for uring seven days.	ling catheter should have to today. ed 4/8/25 documents: ne Culture. 4/9 25 documents: Urine further review. eport dated 4/8/25 documents: n Date: 4/8/2025 22:14 Cloudy (Reference Range: Reference Range: Ref	S9999			
	issued	140 VIOIALIOIT				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6007793	B. WING		04/1	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GENERATIONS AT REGENCY 6631 MILY NILES, IL			NAUKEE AV 60714	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	(2 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)2) Section 300.610 Readler and an analysis of section and an area change in a resider health, safety or we but not limited to, the manifest decubitus of five percent or manifest decubitus of five percent or manifest decubitus and an analysis of section and an area change in a resider health, safety or we but not limited to, the manifest decubitus of five percent or manifest decubitus of five percent or manifest decubitus and an analysis of section and analysis of section and an area change in a resider health, safety or we but not limited to, the manifest decubitus of five percent or manifest decubitus of section and analysis of section and analysis of section and analysis of section and se	esident Care Policies shall have written policies and ing all services provided by the policies and procedures shall Resident Care Policy	S9999	DEFICIENCY)		
	accident, injury or of notification. Section 300.1210 C Nursing and Person	care or treatment of such change in condition at the time. General Requirements for hal Care. shall provide the necessary.				

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STATE FORM 6899 VN6011 If continuation sheet 4 of 9

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6631 MILWAUKEE AVENUE NILES, IL 60714 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
GENERATIONS AT REGENCY 6631 MILWAUKEE AVENUE NILES, IL 60714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			IL6007793	B. WING		04/11/2025	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) NILES, IL 60714 D PROVIDER'S PLAN OF CORRECTION (X5) COMPLET (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	GENERA	ATIONS AT REGENCY			ENUE		
	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	.D BE	COMPLETE
Continued From page 4 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: 2) All treatments and procedures shall be administered as ordered by the physician. These regulations were not met as evidence by: Based on observations, interviews, and record reviews, the facility failed to document accurate meal intakes, offer alternative meal options, and notify the physician or nurse practitioner of significant weight loss. Additionally, the facility failed to implement the dietitian's recommendations and follow the physician's orders to increase Remeron for weight management. This deficient practice affected two of the seven residents (R62 and R103) reviewed for nutrition and unplanned weight loss prevention. As a result, Resident R62 experienced a 10% unplanned weight loss over a six-month period. Findings include: R103 was admitted to the facility on 10/19/2020 with a diagnosis of parkinsonism, dementia, and contractures.	\$9999	care and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal or resident to meet the care needs of the releach resident to meet the care needs of the release	o attain or maintain the highest I, mental, and psychological sident, in accordance with a prehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. subsection (a), general acclude, at a minimum, the be practiced on a 24-hour, basis: atts and procedures shall be dered by the physician. were not met as evidence by: ons, interviews, and record failed to document accurate alternative meal options, and or nurse practitioner of a practitioner of a practice affected two and follow the physician 's Remeron for weight deficient practice affected two ants (R62 and R103) reviewed colanned weight loss sult, Resident R62 unplanned weight loss over a to the facility on 10/19/2020	\$9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6007793	B. WING		04/1	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GENERATIONS AT REGENCY 6631 MILV NILES, IL		VAUKEE AVI 60714	ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	Dietician follow up. down x past 6 mon and current nutrition discussed with Nur receiving Super cer q meal, Pro-Stat St. Remeron 7.5 mg at Practitioner was ag Remeron to 15 mg R103's nurse pract 1/17/25: patient seevisit: Weight loss. of with dietician will incontinue all interveron dining room for lund setting up R62's trareplacing the cover wheelchair out of different out of different cover over and left dining room removing R62's trareplates. R62 did not On 4/9/25 at 11:13/expects his recommunities the physicia recalls speaking to about increasing R6 R103. V7 said R103 which is considered R103's medication	Resident's weight has trended ths, in which weight history nal interventions were se Practitioner. Resident is real at breakfast, Health Shake ugar Free 30 ml every day and t bedtime, thus Nurse greeable to increasing dose of q HS. itioner progress notes dated en and examined. Reason for dietician following discussed crease Remeron to 15mg ntions per dietician. PM, R62 was observed in ch meal. Staff were observed on plate and self-propelling ining room. PM, R62 was observed elchair into dining room. R62 r plate then replaced cover n. Staff were observed y and place on the cart for dirty t consume meal. AM, V7(dietician) said he mendations to be followed n does not agree. V7 said he the V12 (nurse practitioner) emeron due to weight loss for 3 body max index was 14.3	S9999			
		sive 0.5 tablet (7.5MG) orally at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GENERATIONS AT REGENCY 6631 MILW NILES, IL		VAUKEE AVI 60714	ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 6	S9999			
	bedtime.					
	dietitian) stated that each month. V7 staresident be re-weig weight of 5 or more stated that resident monitored and disc with the interdisciplication of the would expas ordered. V12 sarelied to the nurse to computer system.	AM, V7 RD (registered t V7 audits all resident weights ated that V7 will request a hed if there is a change in pounds in one month. V7 s with weight loss are uss during morning meeting inary team. PAM, V12 (Nurse practitioner) ect her orders to be followed id any new orders are verbally o put into the electronic /12 said Remeron would be rease a resident's appetite with				
	practical nurse) star nurse aides) documeach resident in the charting. V15 state nurse if the residen questioned if V15 w lunch on 4/8, V15 d	·				
		g, dated 4/8/25, does not note inch was documented.				
		rd does not note any 1/8/25 related to R62 not				
		an order sheet) notes an order entrated Sweets) diet, Regular in consistency.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLI	:R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GENERATIONS AT REGENCY 6631 MILW NILES, IL		WAUKEE AV 60714	ENUE		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
On 3/10, R62's we On 1/8, R62's weight door loss for 6 months. V7 RD (registered notes significant weight record for Weight over 1, 3 month - 3/10/25 130.6(4.3%), and 139(10.1%). Significant weight is unplanted to a combination mealtimes and be diagnosis of demailmes and be diagnosis of demailmes, in whole the diagnosis of demailmes and share the diagnosis of demailmester the diagnosis of demailmester to have a psychic has the tendency throughout the diagnosis of demailments and the diagnos	eumentation: weight was 125 pounds reight was 128 pounds reight was 130.6 pounds s weight was 139 pounds				

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concerns and recommendations to the

STATE FORM 6899 VN6011 If continuation sheet 8 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
		IL6007793	B. WING		04/1	1/2025
NAME OF I			DDEOG OITY (27ATE 7/D 00DE	1 04/1	1/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S VAUKEE AV I	STATE, ZIP CODE		
GENERA	ATIONS AT REGENCY	NILES, IL		ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	appropriate departn	nent for action. The director	S9999			
	resident representa significant or trendir	nee will ensure physicians and tives are informed of any weight fluctuations or a change in the resident's				
	Facility policy physician orders revised 5/2017 documents: all residents medications, and treatments must be ordered by a licensed physician or nurse practitioner. Physician orders must be reviewed every 60 days. The nursing staff member who took the order or the one assigned to the resident is responsible to transcribe the order. On monthly basis, the physician orders will be reviewed for accuracy by nursing personal.					
	(B)					

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