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 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HCN AT OAKTON PAV	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
S9999	Final Observations	S9999		

LICENSURE VIOLATIONS:
300.1210b
300.3240a)

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 resident to meet the total nursing and personal care needs of the resident.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on interview and review of documents the facility failed to provide adequate supervision in one of three residents sampled. Facility staff left R1 in the toilet room by herself without adequate supervision .

This resulted in R1 receiving a 3 centimeter laceration to her left forehead and a fractured left femur.

FINDINGS:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

R1 is a 87 year old female with a diagnosis including Dementia , Alzheimer Disease , Memory Loss , Dizziness and Giddiness and a Left Hip Fracture from a previous fall at facility on 7/14/14. R1 was first admitted to the facility on 7/1/14.
R1 was assessed by the facility with poor safety awareness, risk for falls, and was on fall precautions. R1 is alert but confused and very forgetful.
R1s latest physician orders indicate that on 7/29/14 she had a urinary tract infection and was ordered Amoxicillin 250 milligrams by mouth three times daily for ten days. R1 was also ordered to be on hip dislocation precautions.

Review of documents reveal R1 had two falls. The first was on 7/14/14 while in the dining room at lunch R1 stood up from chair and fell. R1 was sent out to the hospital and was diagnosed with a left hip fracture.
The 2nd fall was on 8/2/14 at 7:30AM . R1 was brought to her (Room 417) toilet room. E3 (Certified Nurse Aid) left R1 unattended on the toilet. When E3 returned R1 was found laying on the floor. R1 sustained a laceration to the left side of forehead R1 was sent out to the hospital. R1 was admitted to the hospital and diagnosed with a left femur fracture. R1 did not return to the facility.
E3 (Certified Nurse Aid) 11:20AM 8/12/14 stated R1 was sitting up in her bed around 7AM on 8/2/14. I took her to the toilet room and sat her down on the toilet. I gave her the nurse call and told her to pull it when she is ready. I stepped out of her room for two to three minutes to get a diaper down the corridor. When I returned R1 was on the floor. The call light was not pulled. I made a mistake. I should not have left her.

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S9999	Continued From page 2 E4 (Nurse) 1:07PM 8/12/14 stated at the start of my shift at approximately 7AM , I was notified by other staff that a resident was on the floor. E3 stated to me that R1 wanted to use the toilet . E3 left her for a few minutes. When he came back R1 was on the floor. E4 stated that R1 had a urinary tract infection and was even more confused. R1 should not have been left by herself. Document review of incidents shows on 8/2/14 at 7:30AM , E3 took R1 to her toilet and left her . When E3 returned R1 was on the floor on her left side. There was blood on her face. R1 sustained a deep 3 centimeter laceration on her left forehead and a bump / bruise on the left eyebrow. R1 was assessed by staff and the ambulance was called. Hospital records dated 8/2/14 show R1 sustained lacerations to her forehead and a fracture to the left proximal femoral diathysis. R1 required surgery to repair the fracture. (A)	S9999		

Imposed

Comments reviewed

Re: Licensure Findings: 300.1210b

300.3240a

Corrective Actions: E3 has been made aware that he should not leave residents unattended on the toilet, particularly confused residents that may be at high risk for fall.

Identification of Other Residents: All residents are at risk for being negatively affected if they are left unattended in an unsafe situation.

Measures facility will take to ensure problem will be corrected and not recur –

Nursing staff have been in serviced regarding the need to have personal hygiene supplies readily available.
Nurses will communicate to Certified Nursing Assistants any change in cognition of the residents they are assigned to care for.

Quality Assurance Plans: Director of Nursing or her designee will periodically monitor accessibility of personal hygiene supplies. Nurses on duty will periodically be asked as to the cognitive changes of any of the residents on their unit, and if that information had been communicated to other staff members caring for the resident.

Date of Completion: September 3, 2014