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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6006837 01/15/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1660 OAKTON PLACE GENERATIONS HCN AT OAKTON PAV DES PLAINES, IL 60018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

YYMR11

TITLE

(X6) DATE

Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6006837 01/15/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1660 OAKTON PLACE **GENERATIONS HCN AT OAKTON PAV** DES PLAINES, IL 60018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 S9999 Continued From page 1 injury or change in condition at the time of notification. 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 evidence by: Based on interview and record review, the facility failed to inform the physician promptly of significant changes in clinical condition. This had delayed the treatment which resulted to an admission to the hospital with diagnoses of dehydration and acute kidney injury. This applies to one of three residents (R1) reviewed for dehydration. The findings include: The POS (Physician Order Sheet) for the month of December 2014 showed that R1 has multiple diagnoses that include Dementia, Early Memory

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Loss, Depression, Hyperlipidemia, and Mild

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6006837 01/15/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1660 OAKTON PLACE GENERATIONS HCN AT OAKTON PAV DES PLAINES, IL 60018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 Hypertension. The MAR (Medication Administration Record) dated 12/22/2014 to 12/31/2014 and the nurse's notes dated 12/16/2014 to 12/31/2014 showed that R1 had a fever for 11 out of 16 days. The nurse's notes from 12/24/2014 to 12/31/2014 randomly documents that R1 was noted with increased weakness, poor appetite and lethargy. There was no documentation in the clinical record that Z1 (R1's Attending Physician) was notified regarding R1's lingering fever, poor appetite. weakness and lethargy. On 12/31/2014 at 8:00 A.M., the nurse's notes documents that "(R1) continue to be weak. lethargic and sleepy and seemed like has trouble keeping her head up straight." Further review of the nurses notes document that at 3:30 P.M. 4:00 P.M., R1's family member visited and told E12 (Registered Nurse) that R1 was "not talking, confused and mild drooping of the left side of the face." R1 was sent to the hospital after Z1 was notified and was admitted with dehydration and acute kidney injury. On 1/6/2015 at 1:45 P.M., E6 (Registered Nurse) stated that that Z1 was not notified not until 12/31/2014 regarding R1's lingering fever, weakness, increasing lethargy and poor appetite. On 1/6/2015 at 2:40 P.M., E7(LPN, Licensed Practical Nurse) stated that R1 was noted with increasing weakness, poor appetite, fever and slow to response for almost two weeks prior to R1 being transferred to the hospital on 12/31/2014. E7 stated that Z1 was notified on 12/31/2014 regarding R1's current medical

Concern.

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condition when R1's family visited and was

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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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S9999	Continued From pa	ige 3	S9999			
	Assistant, CNA) staincreased weakness appetite for the pass transferred to hospin had informed E6 re On 1/6/2015 at 2:34 he noticed R1 to be weakness and poor weeks prior to R1 b On 1/12/2015 at 11 was not notified reg weakness, lethargy fever for the past two hospitalization on 12 could have ordered work, intravenous fl sooner for an imme prevent dehydration also added that dehydration also added that dehydration as the pass two hospitalization on 12 could have ordered work, intravenous fl sooner for an imme prevent dehydration also added that dehydrati	5 P.M., E8(Certified Nurse ated that R1 was noted with as, slow to response, poor at two weeks prior to R1 being ital. E8 also stated that she garding R1's declined. 4 P.M., E9 (CNA) stated that a "sleepier, increasing appetite" for the past few being sent to the hospital. 45 A.M., Z1 stated that he parding R1's increased, poor appetite and an ongoing two weeks prior to 2/31/2014. Z1 also stated he intervention such as blood and acute kidney injury. Z1 and acute kidney injury. Z1 and acute kidney injury. Z1 and acute timely treatment was in				
THE REPORT OF THE PARTY OF THE	12/31/2014 indicate acute kidney injury urinary tract infectio hospital record date was placed on pallia	ency department record dated at that R1 was admitted with with "marked dehydration, on and pansinusitis." The add 1/7/2014 indicated that R1 ative care and was discharged facility and was placed on				
	Condition or Status' the nurse will notify physician when "T	for "Change in a Resident's ' dated 12/2013 showed that the resident's attending There is a significant change in cal, mental; Deemed			TOTAL CONTRACTOR CONTR	

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Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING ___ IL6006837 01/15/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1660 OAKTON PLACE **GENERATIONS HCN AT OAKTON PAV** DES PLAINES, IL 60018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 necessary or appropriate in the best interest of the resident." (B)

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