STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Neighbors	811 West 2nd Byron, IL 61010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADL) assistance to 2 of 3 residents (R63,R86) reviewed for activities of daily living in the sample of 20. The findings include: 1) R63's electronic face sheet printed on 9/5/24 showed R63 has diagnoses including but not limited to Alzheimer's disease, major depressive disorder, dementia with psychotic disturbance, and type 2 diabetes. R63's facility assessment dated [DATE] showed R63 has moderate cognitive impairment. R63's Restorative assessment dated [DATE] showed R63 requires maximum assistance for oral hygiene and personal hygiene. R63's care plan dated 3/9/23 showed, (R63) is at risk for ADL decline related to muscle weakness, dementia, and anxiety .dependent on staff for personal hygiene. On 9/4/24 at 8:50AM, V5 (Certified Nursing Assistant/CNA) provided morning care for R63. V5 provided incontinence care, dressing assistance, and brushed R63's hair. V5 did not provide or offer to brush R63's teeth or provide any oral care. R63 had facial hair on her chin, above her top lip, and around the sides of her mouth. V5 did not provide or offer any shaving assistance to R63. V5 stated residents receive oral care each morning and every night before bed. V5 stated residents receive shaving assistance (male and female) on shower days. V5 stated she is unsure why she did not provide oral care or shaving assistance to R63. On 9/4/24 at 10:05AM, Surveyor asked R63 if she preferred to have facial hair or if she was used to having it shaved. R63 then felt her face and stated, Oh my goodness! I need this taken care of. I do not like facial hair. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated policy titled, Activities of Daily Living (ADLs) showed, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL's .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) . 2) R86's electronic face sheet printed on 9/5/24 showed R86 has diagnoses including but not limited to severe protein-calorie nutrition, and dementia with behaviors. R86's facility assessment dated [DATE] showed R86 has moderate cognitive impairment and is incontinent of bladder. R86's care plan dated 9/3/24 showed, Resident experiences incontinent episodes of bowel and bladder provide incontinent care after each incontinent episode. On 9/3/24 at 12:15PM, V6 (CNA) provided toileting assistance to R86. V6 removed R86's incontinence brief and stated it was wet with urine and had feces on it. V6 then applied a new incontinence brief to R86 and pulled her pants up without providing incontinence care. V6 stated she is a new aide and that R86 usually just wipes herself with toilet paper, so she didn't think she needed to wash her. On 9/5/24 at 10:46AM, V2 (Director of Nursing) stated, When a resident is incontinent, they should receive incontinence care for infection prevention, dignity, and cleanliness. It's standard of practice and all aides know this and are trained to do this. Morning care for all residents includes incontinence care (if they are incontinent), dressing, grooming (including coming hair, washing their face, and offering to help them brush their teeth), and anything else that the resident would ask for. All residents with facial hair, regardless of if they are male or female should be shaved on shower days and as needed if the resident is okay with it. The facility's policy titled, Incontinence Care dated 5/2017 showed, Objective: To keep the skin clean, dry, free of irritation and odor . The facility's undated policy titled, Perineal Care showed, Objective: 1. To cleanse the perineum. 2. To prevent infection and odors .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure an indwelling urinary drainage bag remained below the bladder level for 1 of 2 residents (R61) reviewed for catheters in the sample of 20. The findings include: R61's undated face sheet showed diagnoses including but not limited to cerebral infarction, heart disease, obstructive and reflux uropathy, benign prostatic hyperplasia, and urinary tract infection. R61's facility assessment dated [DATE] showed moderate cognitive impairment and the use of a urinary catheter. The same assessment showed total staff assistance required for transfers. R61's September 2024 physician order report showed the use of an indwelling catheter for urinary retention start dated 8/8/24. R61's August 2024 medication administration history report showed the use of cephalexin and levofloxacin (antibiotics) were given to treat a urinary tract infection (UTI). On 9/3/24 at 9:53 AM, R61 was lying in bed and was alert. R61's catheter bag was in the bed laying on top of his thighs, near the groin area. Yellow urine was visible in the tubing and bag. R61 stated he was waiting for the aide to return and transfer him from the bed to his wheelchair. At 10:06 AM, V2 (Director of Nurses/DON) and V7 (Certified Nursing Assistant) entered the room and transferred R61 using a mechanical lift. During the transfer V2 stated she would hold the bag to be sure it stays below his bladder. On 9/4/24 at 12:32 PM, V2 (DON) stated R61 needed antibiotics a few weeks ago due to a urinary tract infection. His catheter bag needs to be below his bladder to prevent the back flow of urine. The backflow can cause UTIs. The catheter bag should not be laying in his lap or in bed with him. The bag should be placed on the bed rail until care is provided. R61's care plan showed a focus area related to the use of an indwelling catheter. Interventions included: position bag below the level of the bladder. The facility's undated Closed Urinary Drainage policy states under the procedure section: 3. Attach drainage bag to bed frame, below level of resident's bladder, not touching the floor, to allow flow with gravity and avoid back flow of urine.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to ensure accurate weights were obtained and recorded for 5 of 5 residents (R13, R47, R86, R95, R98) reviewed for nutrition in the sample of 20. The findings include: 1) R98's electronic face sheet printed on 9/5/24 showed R98 has diagnoses including but not limited to necrotizing fasciitis, cerebral infarction, diarrhea, cutaneous abscess of groin, and chronic pain. R98's weight log showed, 7/27/24 197.4lbs 7/28/24 175.6lbs (21.8lb weight loss in 1 day). 8/2/24 195.4lbs 8/3/24 188.4lbs (7lb weight loss in 1 day). 8/6/24 192.8lbs 8/8/24 182.8lbs (10lb weight loss in 2 days). R98's nursing progress notes for July-August 2024 showed no documentation that R98 was reweighed or that a physician was notified of any significant weight loss. On 9/5/24 at 10:46AM, V2 (Director of Nursing/DON) stated, When a significant weight change is identified, staff should get a reweigh on the resident to ensure the weight is accurate. As a nurse, I would say the standard of care would be 5 or more pounds in a day would constitute a reweigh. It could be that staff didn't subtract equipment, but they should be identifying the weight loss when they are entering it into the system. The facility's policy titled, Weight Management dated 03/22 showed, Objective: 1. It is the policy of this facility to monitor the nutritional status of all residents, including all significant or trending patterns of weight change to maintain acceptable parameters of nutritional status .4. All significant, unplanned, or trending weight changes must be investigated by the facility .5. In the case of a significant or trending weight change the following steps will be taken: 1. Determine the possible cause . 2) R47's electronic face sheet printed on 9/5/24 showed R47 has diagnoses including but not limited to hypertensive heart disease, major depressive disorder, peripheral vascular disease, atherosclerosis, pulmonary embolism, emphysema, anxiety disorder, and type 2 diabetes. R47's weight log showed, 6/19/24 228.4lbs 6/20/24 255lbs (26.6lb weight gain in 1 day). 6/21/24 254.1lbs 6/22/24 224.4lbs (29.7lb weight loss in 1 day). 8/5/24 238lbs 8/6/24 244lbs (6lb weight gain in 1 day). R47's nursing progress notes for June-August 2024 showed no documentation that R47 was reweighed or that a physician was notified of any significant weight changes. 3) R86's electronic face sheet printed on 9/5/24 showed R86 has diagnoses including but not limited to severe protein-calorie nutrition, and dementia with behaviors. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R86's weight log showed, 7/17/24 99lbs 7/18/24 93.6lbs (5.4lb weight loss in 1 day). 7/21/24 98.8lbs 7/22/24 93.4lbs (5.4lbs weight loss in 1 day). 8/30/24 101.6lbs 9/1/24 94.6lbs (7lb weight loss in 1 day). R86's nursing progress notes for July-September 2024 showed no documentation that R86 was reweighed or that a physician was notified of a significant weight change. 38488 4. R13's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, Cardiomyopathy, peripheral vascular disease, Chronic Congestive Heart Failure, and hypertensive heart disease. R13's September 2024 Physician Order Sheet showed an order started 7/6/23, daily weight. R13's July 2024 daily weights showed 7/1/24 she weighed 186 lbs. and on 7/2/24 she weighed 174.6 lbs. This shows an 11.4 lbs. weight loss in 1 day. R13's next weight 7/3/24 showed she weighed 185.6 lbs. which would be an 11 lbs. weight gain in 1 day. R13's 7/14/24 weight was 186.2 lbs. and on 7/15/24 she weighed 181.8 lbs. (4.4 lbs. weight loss in 1 day). R13's 7/16/24 weight was 183.6 lbs. and R13's 7/17/24 weight was 187 lbs. (3.4 lbs. weight gain in 1 day). R13's complete medical record was reviewed and showed no reweighs were completed. R13's August 2024 daily weights showed 8/6/24 she weighed 187.0 lbs. and 8/7/24 she weighed 197.2 lbs. This shows a 10.2 lbs. weight gain in 1 day. R13's complete medical record showed was reviewed and no reweighs were completed. On 9/05/24 at 9:52 AM, V3 (Assistant Director of Nursing/ADON) said notification to a physician of weight changes would depend on if the resident has an order for parameters to notify. V3 said some residents will have parameters on their order for daily weights. V3 said she would guess most of the residents that are daily weights have parameters noted on their orders for notification. V3 said if there is a large discrepancy when they get the resident's weight, she would expect the nurses to get a reweigh and anytime there is doubt in the accuracy of the weight they should reweigh. V3 reviewed R13's weights and said she would expect a reweigh with the changes in R13's weights that were noted. V3 said a 10 lbs. discrepancy would be inaccurate because there is no way someone could gain or lost 10 lbs. in one day. 36186 5. The face sheet for R95 shows she was admitted to the facility with diagnoses to include obesity, depression, hypothyroidism, anxiety, and bipolar disorder. The facility assessment dated [DATE] shows R95 to be cognitively intact and requires moderate assistance from staff for her activities of daily living. The weights for R95 shows on 7/20/24 she weighed 191.8 pounds (lbs.) and on 7/23/24 her weight was 202. 8 lbs. On 7/28/24 R95's weight was 200.8 lbs. and on 7/29/24 her weight was down to 190.8 lbs. No notification to the Physician of the changes to R95's weight could be found, and no re-weigh was documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The weights for R95 on 8/12/24 showed her to weigh 191.8 lbs. and the next day she weighed 181.4 lbs. No notification of the weight changes was documented as being reported to the Physician and no re-weigh was obtained.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38488 Based on observation, interview, and record review the facility failed to securely store medications. This applies to 1 of 6 medication carts reviewed for medication storage. The findings include: On 9/5/24 at 10:45 AM, V3 (Assistant Director of Nursing) was assisting this surveyor during medication storage review. V3 said she had to find the nurse on the hall to get the keys to the cart and walked away from the surveyor. When V3 returned to the medication cart she opened the narcotic count binder that was laying on the right side of the cart and the nurse's keys were laying just under the binder cover. V3 removed the keys from the binder and proceeded to open the medication cart. On 9/5/24 at 10:50 AM, V3 said the keys to the medication cart and medication rooms should be on the nurse and not laying on the medication cart. V3 said she did not know why the nurse would have left the keys on the cart. On 9/05/24 at 11:33 AM, V2 (Director of Nursing) said the keys to the medication cart should be with the nurse at all times. V2 said it is important to keep the medications secure and to make sure none of the residents get into the medication cart as they could possibly ingest medications. V2 said it is important to maintain secure medication storage to ensure both patient safety and medication control. The facility's policy and procedure with revision date of 8/2023 showed, Storage of Medications; Objective: Drugs and biologicals shall be stored in a safe, secure, and orderly manner .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to perform glove changes and hand hygiene during incontinence care for 1 resident (R61). The facility also failed to transport linens in a manner to prevent cross contamination on 1 of 5 units. These failures apply to 14 of 14 residents reviewed for infection control in the sample of 20. The findings include: 1. The facility roster dated [DATE] showed 13 residents residing on the unit where V5 (Certified Nursing Assistant/CNA) was working on [DATE]. On [DATE] at 8:50AM, V5 provided incontinence care to R63. R63's bed pad was saturated with urine when V5 picked up R63's soiled linen, held it against her body, and transported it down the hallway to the soiled linen container. V5 did not bag R63's soiled linen. V5 returned to R63's room, completed her cares, then left R63's room and went to the dining room to assist with the remainder of the breakfast meal. V5 did not change her clothing and stated she knows she should have put the soiled linens in a bag to transport it down the hall, but she was nervous. V5 stated she takes care of all the 13 residents on R63's unit throughout the day. V5 stated she does not have a change of clothes and intends to wear her soiled clothing for the remainder of the day. On [DATE] at 10:46AM, V2 (Director of Nursing) stated, It is our policy that the aides bring a soiled linen cart to the doorway of each resident's room when they are providing care, so they do not have to transport the soiled linens down the hall. If they are unable to bring the cart to the doorway, then they need to bag the soiled linens and transport them to the soiled linen cart that way. The way (V5) transported the linens is an infection control concern as the linen (V5) was carrying was soiled with urine. On [DATE] at 10:59AM, V4 (Infection Preventionist) stated, When staff are transporting soiled linens, they should be carried away from body and straight into the soiled linen bin. It is important to carry the linens away from their body for infection control purposes as they don't want to transfer anything to another resident. The facility's policy titled, Laundry Handling revised ,d+[DATE] showed, Objective: Soiled linen contaminated with blood or other potentially infectious materials will be handled as little as possible and with a minimum of agitation .3. Contaminated laundry will be placed and transported in bags or containers . 34891 2. R61's undated face sheet showed diagnoses including but not limited to cerebral infarction, heart disease, obstructive and reflux uropathy, benign prostatic hyperplasia, and urinary tract infection. R61's facility assessment dated [DATE] showed moderate cognitive impairment and the use of a urinary catheter. The assessment showed substantial/maximal staff assistance required for toileting and personal hygiene. The same assessment showed R61 is always incontinent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:08 AM, V8 and V9 (CNAs) entered R61's room and donned PPE (personal protective equipment) to perform incontinence care. The CNAs put on gowns and gloves (as required for the enhanced barrier precaution). R61 was rolled to his side and was heavily incontinent of bowel. V8 steadied the resident while V9 cleansed the bowel movement off his lower back, buttocks, and inner thighs. V9 continued wearing the contaminated gloves and handed R61's catheter bag to V8. V9 opened the bedside table drawer and removed a tube of medicated skin cream. R61 was rolled onto his back while V9 cleansed the bowel movement off his groin area, catheter tubing, and leg strap. V9 continued wearing the soiled gloves while V8 exited the room for more incontinence supplies. V9 wore the same gloves while changing the bed pad under R61, using the bed remote, and leaning on the bed side rails. V9 finally changed her gloves and stated she does it between dirty and clean items. V9 said she waits until she is completely done with incontinence care before changing her gloves. V9 said she puts on clean gloves just before she helps R61 to get dressed. On [DATE] at 12:32 PM, V2 (Director of Nurses) stated gloves should be changed between dirty and clean areas. Soiled gloves should be removed, hands washed, and new gloves put on before touching anything. It is important for infection control. Germs, feces, and urine will transfer to clean areas if contaminated gloves are worn. Gloves need to be changed several times during incontinence care. It is incorrect to wait until the end to change them. The facility's undated Gloves policy states: 2. When gloves are indicated they shall be used only once and discarded into the appropriate receptacle.