STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145626	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations Oakton Pavillion	1660 Oakton Place Des Plaines, IL 60018

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observation, interview, and record review, the facility failed to follow their policy and procedure for housekeeping by not ensuring the rooms and medical equipment of residents who are totally dependent on staff for care and assistance with activities of daily living, were consistently and adequately cleaned and sanitized. This failure applies to four of four residents (R1, R2, R3, R4) reviewed for environment. Findings include: 1. R1 is a [AGE] 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 multiple dresser drawers near R1's bed open and a mild odor present. On 02/10/2025 at 10:54 AM Observed R1's oxygen machine with visible dust and particles. V5 (Registered Nurse) was present and verbally confirmed the observation and stated the oxygen equipment should be clean. Observed a clean dressing dated 02/10/2025 sitting on R1's dresser near the foot of his bed. Observed R1's respiratory equipment with visible dust in the crevices on the top of the machine. V5 verbally confirmed the observation and wiped away some of the dust to further confirm that the area was unclean. V5 stated there shouldn't be any visible dust on the respiratory equipment. Observed a brown substance spilled over on multiple areas of R1's feeding tube monitor and pole. Observed R1's dresser near the foot of his bed with multiple uncovered and exposed plastic syringes. V5 stated that one of the syringes was for stool collection and the other is for feeding tube flushing and they should both be covered and stored properly. Observed a refrigerator in R1's room with visible dust and particles on the creviced exterior and with visible residue in multiple areas of the exterior. V5 stated the refrigerator exterior surface should be clean and free of visible matter. Observed multiple dresser drawers open. V5 agreed that R1's drawers should be closed and stated it only takes a moment to close them. 2. R2 is a [AGE] year-old female with a diagnoses history of Partial Paralysis following Brain Related Bleeding, Feeding Tube Placement, Protein Calorie Malnutrition, and Dysphagia (Difficulty Swallowing Foods) who was admitted to the facility 01/23/2025. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145626	A. Building B. Wing	02/13/2025

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/2025 at 11:22 AM Observed R2's oxygen machine with visible dust and particles, a large mat next to the right side of her bed with multiple visible stains and residue, R2's respiratory equipment with visible dust and particles in multiple areas, an uncovered plastic feeding tube suction syringe and a plastic glove sitting directly on top of R2's window seal, multiple yellow spots on R2's window seal and underneath the uncovered plastic feeding tube syringe, R2's feeding tube equipment with a brown substance spilled over onto the monitor and pole, and R2's night stand beside her bed with multiple open drawers with visible dust on the borders of them and visible dust on the top and side exterior of the night stand. R2's current care plan documents she is bed bound, she receives nothing by mouth and her sole source of nutrition and hydration is via enteral feeding related to diagnoses of Dementia, Congestive Heart Failure, Diabetes Mellitus, and Renal Disease or Liver Disease and is dependent with tube feeding. R2's current physician orders include an active order effective 01/23/2025 for Enteral Feeding: Tube Site Care of cleansing with normal saline solution, patting dry, and applying a drain sponge and tape every night shift. 3. R3 is an [AGE] year-old female with a diagnoses history of Alzheimer's Disease, Dementia, Protein Calorie Malnutrition, Aphagia (Inability to Swallow) and Dysphagia (Difficulty Swallowing Foods) who was admitted to the facility 03/16/2023. On 02/10/2025 at 11:14 AM Observed R3's oxygen machine with visible dust and a substance spilled on the floor directly behind it, R3's respiratory equipment with visible dust, a brown substance spilled over on multiple areas of R3's feeding tube monitor and pole, and visible dust and particles on R3's bed frame underneath the head of her bed. V2 (Director of Nursing) was also present and verbally confirmed these observations and stated they would be addressed. 4. R4 is a [AGE] year-old female with a diagnoses history of Stroke, Partial Paralysis, Dysphagia (Difficulty Swallowing), Feeding Tube Use, and Need for Assistance with Personal Care who was admitted to the facility 11/08/2024. On 02/10/2025 at 11:07 AM Observed a refrigerator in R4's room with visible dust and particles on the creviced exterior and with visible residue in multiple areas of the exterior. Observed large padding next to R4's bed with visible stains and residue. V5 (Registered Nurse) was present and verbally confirmed the observations and wiped the padding with a wet towel to confirm the stains could be removed. V5 stated the padding should be clean and free of visible substances. Observed R4's oxygen machine with visible dust and particles. V5 verbally confirmed these observations and stated there should not be any visible dust or other substances present on oxygen equipment. Observed multiple orange spots on R4's window seal and air conditioner. V5 verbally confirmed these observations and stated the spots should not be on R4's window seal. (continued on next page)

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	145626	A. Building B. Wing	02/13/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/2025 at 11:59 AM V6 (Housekeeping Supervisor) stated nursing is responsible for cleaning the resident's medical equipment because housekeeping staff would be afraid to move the equipment and potentially disconnect something. V6 stated housekeeping staff are responsible for cleaning residents rooms daily which includes blinds, bed frames, padding, nightstands, window seals etc. which ensures these areas stay clean. V6 stated one of the housekeeping staff became ill six weeks ago and she plans on hiring more staff. V6 confirmed there should not be any visible dust, residue, substances, stains, or particles if the residents rooms are cleaned daily. 02/11/2025 1:41 PM V2 (Director of Nursing) and V5 (Registered Nurse) stated the Respiratory Therapists are responsible for replacing and cleaning respiratory care equipment and they have a schedule for this. V2 stated maintaining the cleanliness of resident's respiratory and feeding tube equipment is a collaborative effort which includes respiratory and nursing staff. V2 confirmed aides, nurses, and respiratory staff are all responsible for maintaining the cleanliness of respiratory and feeding tube equipment. When asked by surveyor if staff enter the residents room and observe their respiratory or feeding tube equipment to be unclean should the equipment be left in that condition, V2 stated this should be addressed. The facility's Daily Housekeeping Policy received 02/10/2025 states: Disinfect horizontal surfaces (dressers, nightstands, etc.). Disinfect high touch surfaces (medical equipment).

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NAME OF PROVIDER OR SUPPLIER Generations Oakton Pavillion		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Oakton Place Des Plaines, IL 60018	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for feeding tube care by not following physician orders of daily cleansing and dressing of feeding tube site for residents dependent on enteral nutrition. This failure applied to four of four (R1, R2, R3, and R4) residents reviewed for quality of care. Findings include: 1. R1 is a [AGE] 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 and bed bound. Observed V3 (Registered Nurse) uncover R1's feeding tube surgical site to reveal the site to be without a bandage/dressing and with a noticeable scab present. V3 stated feeding tube site dressings should be changed every night shift and R1 does not have a dressing over his site. V3 stated she observed R1's feeding tube surgical site with a dry scab that should be cleaned and have a new dressing applied to it. R1's current care plan documents he receives nothing orally and currently receives nutrition by feeding tube with interventions including change enteral feeding tube dressing per physician's order; 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 change feeding tube dressing per physician's orders, check the feeding tube site regularly for signs/symptoms of infection such as redness, drainage etc.; registered dietitian to provide monthly nutrition assessment and evaluate calorie, protein, and fluid needs and adequacy/appropriateness of current feeding regimen, report any early signs of fluid overload or dehydration to the physician for further medical evaluation. R1's current physician orders include an active order effective 02/01/2025 for Enteral Feeding: Tube Site Care of cleansing with normal saline solution, patting dry, and applying a drain sponge and tape every night shift and as needed for feeding tube surgical opening. R1's February 2025 Treatment Administration Record documents missing information for Enteral Feeding Tube Site Care per physician's orders on 02/05/2025. 2. R2 is a [AGE] year-old female with a diagnoses history of Partial Paralysis following Brain Related Bleeding, Feeding Tube Placement, Protein Calorie Malnutrition, and Dysphagia (Difficulty Swallowing Foods) who was admitted to the facility 01/23/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Generations Oakton Pavillion		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Oakton Place Des Plaines, IL 60018	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/2025 at 10:36 AM Observed V3 (Registered Nurse) uncover R2's feeding tube surgical site to reveal a dressing labeled 02/05/2025, with some visible brown staining, and not completely sealed with tape. V3 stated there was a scab present at R2's feeding tube site and the site is supposed to be clean before a new dressing is applied. V3 stated feeding tube site dressings should be cleaned and changed every night shift and it doesn't look like R2's was. Observed a scab around R2's feeding tube site. 3. R3 is an [AGE] year-old female with a diagnoses history of Alzheimer's Disease, Dementia, Protein Calorie Malnutrition, Aphagia (Inability to Swallow) and Dysphagia (Difficulty Swallowing Foods) who was admitted to the facility 03/16/2023. On 02/10/2025 at 10:49 AM Observed V4 (Licensed Practical Nurse) uncover R3's feeding tube site and reveal R3's site to be without a dressing. V4 stated she observed R3's feeding tube site with a bit of drainage that appears old and there is no dressing present. V4 stated the night shift typically replaces feeding tube site dressings. V4 stated dressings should be present and dated. R3's current care plan documents she is bed bound, she requires a tube feeding related to Dysphagia, receives nothing by mouth and her sole source of nutrition and hydration is by enteral feeding with interventions including requiring total assistance with tube feedings, providing local care to feeding tube site as ordered and monitoring for signs and symptoms of an infection. R3's current physician orders include an active order effective 01/30/2025 for Enteral Feeding: Tube Site Care of cleansing with normal saline solution, patting dry, and applying a drain sponge and tape every night shift and as needed. R3's February 2025 Treatment Administration Record documents missing information for Enteral Feeding Tube Site Care per physician's orders on 02/03/2025. 4. R4 is a [AGE] year-old female with a diagnoses history of Stroke, Partial Paralysis, Dysphagia (Difficulty Swallowing), Feeding Tube Use, and Need for Assistance with Personal Care who was admitted to the facility 11/08/2024. On 02/10/2025 10:44 AM Observed V4 (Licensed Practical Nurse) uncover R4's feeding tube site and reveal the dressing to be without a date. V4 stated there should be a date on R4's feeding tube site dressing. V4 stated when she examines feeding tube site dressings, she looks for a date, cleanness, and for no drainage to be present. V4 stated she observed R4's feeding tube site with a little bit of crust around it and some dry drainage. R4's current care plan documents she is bed bound, requires a feeding tube feeding related to Dysphagia, and she is dependent with tube feeding with interventions including provide local care to feeding tube site as ordered and monitor for signs and symptoms of infection. R4's current physician orders include an active order effective 11/9/2024 for Enteral - Tube Site Care every night shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/2025 at 11:12 AM V2 (Director of Nursing) stated both V3 (Registered Nurse) and V4 (Licensed Practical Nurse) informed her that four residents feeding tube site dressings were not changed, and the sites should be cleaned, changed, and have a dressing applied each night during the 11 PM - 7:30 AM shift. On 02/11/2025 at 1:41 PM V2 (Director of Nursing) and V5 (Registered Nurse) stated missing entries on the TAR (Treatment Administration Record) could indicate that treatment wasn't administered. V2 stated nurses should document on the TAR to confirm that treatment was administered. The facility's Tube Feedings/Enteral Nutrition Policy received 02/11/2025 states: Gastrostomy Tube care is to be done daily and as needed.

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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 - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40718

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 [AGE] 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 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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(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 - Actual harm Residents Affected - Few	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 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 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.