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	04/25/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders by failing to monitor and apply a resident's negative pressure wound therapy and dressing for a resident with necrotizing fasciitis to the right foot. These failures affect one of three residents reviewed for wound care. This failure resulted in R2 not receiving wound treatment for 5 hours, calling 911, and being transported to local emergency room. Findings include: R2 was admitted to the facility on [DATE] with a diagnosis of necrotizing fasciitis, sepsis, type II diabetes, polyneuropathy and anxiety disorder. R2's brief interview for mental status dated 4/14/25 documents a score of 15/15 which indicates cognitively intact. R2's physician order dated 4/9/25 documents: Right dorsum and plantar foot - Cleanse with Normal Saline Solution (NSS)/wound cleanser, apply negative pressure wound therapy (NPWT) at 125 mmHg (milimeters of mercury) continuous setting every day shift every Tuesday, Thursday, Sunday and as needed. On 4/22/25 at 2:23pm, R2 who was alert and oriented at time of interview said she had a bad wound on her right foot. R2 said on Saturday morning (4/19/2025) she took a shower by herself and disconnected the negative pressure wound therapy . R2 said there was a strong odor coming from her foot and she wrapped her right foot with a towel. R2 said she saw the wound care nurse down the hall after her shower and asked her to come see her but she never came. R2 said she told the social worker and nurse that she needed to see the wound care nurse but they never came. R2 said she waited until around 4 or 5 and said she decided to call 911 because no one was taking care of her foot. On 4/22/25 at 3:53PM, V9 (Certified nursing assistant, CNA) who was assigned to R2 for morning and evening shift was unable to recall if her negative pressure wound therapy was connected during her shifts. V9 said R2 had requested to see the wound care nurse, was unsure of the time but was during the first shift. V9 said the wound care nurse was on the floor and assumed she would see R2 when they did rounds. V9 did not inform anyone of R2's request for the wound care nurse. V9 said she was unsure if R2 was ever seen by wound nurse. On 4/24/25 at 1:34PM, V6 (nurse) who was assigned to R2 day shift 7-3. V6 said R2 wanted to see the wound nurse around 1100am but unsure if she was seen. V6 unable to recall if she called wound care nurse or paged her. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 2:21PM, V14 (social service director) said he was manager on duty on 4/19/2025. V14 said around 11:00 AM, he saw R2 yelling out in the hallway about her foot was in pain and her negative pressure wound therapy device had come off. V14 said R2 was observed with a bath towel around her right foot. V14 said he informed the floor nurse of R2's request to see the wound care. On 4/25/25 253PM, V15(front desk) said she saw R2 at the front desk and she was complaining about her foot. R2 reported the wound care nurse saw her in the hallway but did not come to see her to give her treatment. V15 said she paged the wound care and never received a call back. V15 said she paged again and no return call, V15 said she saw wound care nurse on the unit and just assumed she would eventually make it to R2. V15 did not inform anyone of R2's request or do anything further for R2 request. On 4/22/25 at 3:12PM, V7(nurse) who was assigned to R2 on the evening shift 3-11. Around 3:30, R2 reported that she wanted to go to the hospital to get her wound looked at. V7 said R2 negative pressure wound therapy was disconnected and there was a towel around her right foot. On 4/24/24 at 12:38PM, V13(wound care nurse) said she saw R2 in the morning around 8:00AM. R2 said she put a transparent dressing on her foot which was intact and wound drainage container which was about a quarter full. V13 said she did not see R2 after that encounter and did not receive any reports, concerns, or requests about R2. V13 said if she was aware that R2 needed to be seen she would have seen R2 during her shift. V13 said sometimes they will page her, but she does not hear it when she is in a resident room. On 4/25/25 2:48PM, V2 (ADON) said if staff need to contact the wound care nurse on duty, they would call them on their cell phone or call their office. They can leave a message in mailbox or email. V2 said its not standard protocol to page staff if needed. If a resident is requesting for wound care the nurse should call the wound care nurse. If wound care nurse is not available than they would document, and resident would be seen by wound care next day. V2 said if R2 removed her wound vac or dressing she has an as needed order that should have been followed. On 4/25/25 at 1:29PM, V16 (wound nurse practitioner) said negative pressure wound therapy helps to decrease moisture, aide with healing and help blood flow to the area. If a resident is noncompliant with device, it may be needed to change treatments to a daily dressing. If device is removed or turned off it puts the patient at risk for infection or wound to become larger. R2's April's medication administration record and treatment administration record reviewed with no documentation of any treatments provided to R2 on 4/19/25. Records reviewed do not document any monitoring or checks to R2's negative pressure wound therapy R2's progress note dated 4/19/25 at 6:28PM documents: Resident was noted to be non-compliant with prescribed wound care treatment. She independently removed her wound vac device and placed a towel over the open wound. Upon intervention, resident became visibly upset, began crying loudly, and was inconsolable. Nursing staff administered prescribed pain and antianxiety medications for symptom management. Despite being informed that wound care would be continued in-house, resident insisted on being transferred to the hospital for wound treatment. AMA (Against [NAME] I Advice) paperwork was offered; However, the resident refused to sign. Subsequently, the resident contacted 911. Paramedics arrived and transported the resident to the hospital. There were no other documented nursing progress notes on 4/19/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's care plan dated documents: The resident has post surgical wounds post necrotizing fasciitis to the right dorsum foot and right planter foot, diabetic ulcers to the left ankle, blister on the left dorsum foot, and bruise on the right lower abdomen, and has potential for further skin impairment r/t resistance/non-compliance to care, diabetes, and limited mobility. Interventions include: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; Educate resident/family/caregivers of causative factors and measures to prevent skin injury; Encourage good nutrition and hydration in order to promote healthier skin; Follow facility protocols for treatment of injury; Keep skin clean and dry. Use lotion on dry skin. Do not apply on (Specify: site of injury); Monitor for side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury; Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD (medical doctor); Obtain blood work such as CBC (complete blood count) with Diff (differential), Blood Cultures and C&S (culture & sensitivity) of any open wounds as ordered by Physician; Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface; Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's ambulance run report dated 4/19/25 at 4:03PM documents: (ambulance identifier) dispatched to the incident location for a sick person. Upon arrival, crew found R2 Alert and oriented x4 sitting upright in the nursing home lobby awaiting Emergency Medical Service arrival. Patient advises the crew that she has a chronic open wound on her right foot that she needs care for but has not received. Patient and the patient's husband advises the crew that she has been requesting wound care for the past 5 hours and pain management, but has been ignored by the nursing staff and told they would come back. Crew notes large, deep, and weeping open wound that wraps around the entire right foot. Patient has a wound vacuum to use but is not currently in use and is at the patient's side. Just prior to the crews arrival, patient was administered10-325mg of hydrocodone orally by the nursing staff per the patients PRN records. Patient advised that she was fed up with the nursing staff and needed to be transported somewhere that they would actually care for her. Patient advises the crew that she was sepsis and is currently 7 days into her cephalexin treatment. R2's hospital record dated 4/19/25 documents: R2 presents with right foot pain and erythema form nursing home with not getting proper wound care treatment today. Under skin documents chronic wounds over dorsum and plantar aspects of the right foot, pink granulation tissue with exposed tendon. Erythematous skin surrounding the wounds, swelling to the foot as well. Facility grievance dated 4/19/25 documents R2 around 3:47PM, writer was informed that R2 was asking to go to the hospital for swelling and pain. R2 states she ran into the wound care nurse in the morning and requested her to come and visit her. Wound care nurse still had not come to the room. Facility policy revised 05/17 titled Wound care documents to protect the wound from contamination and control bleeding. Under Wound care documentation documents follow physician ordered for wound care.