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	07/20/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident remained free from staff to resident abuse for one of three residents (R1) reviewed for abuse. This failure resulted in R1 sustaining physical injuries and R1 being transported to the emergency department for treatment, ultimately resulting in R1's request discharge against medical advice due to fear and dissatisfaction with the facility. R1 is a [AGE] year-old with diagnoses including heart failure, epilepsy, hypertension, hyperlipidemia and anxiety disorder. On 7/18/25 at 1:50 PM, V1 (Administrator) said she was the abuse prohibition coordinator and was present in the building due to flooding in the basement that evening she was trying to address when V4 nurse had an altercation with the resident R1. V1 indicated she was told by the resident that V4 hurt his wrists and chest during the altercation and that the resident called 911 and police and fire department came to speak with resident. V1 said she personally walked V4 out of the building at around 8:30 PM to investigate the incident and that she had reviewed the facility security closed circuit television (without audio) but did not believe V4 was at fault however suspended the staff member to follow their abuse policy. V1 then offered to show the video surveillance to the surveyor. Facility security video footage (without audio) captured the incident. Although the verbal exchange could not be heard, the footage showed V4 pointing and motioning aggressively to R1 to return to his room. The video also showed physical interaction consistent with the R1's account, including a posture and mannerisms by the nurse (V4) suggestive of an aggressive and confrontational stance. The video footage further supported that the situation escalated instead of being diffused. V4 is seen motioning with his hands for R1 to come towards him whereupon R1 appears to dash down the hall with clenched fists and confronts V4. V4 appears to remain in place instead of walking away from the situation in order to diffuse further escalation. There appears to be a verbal exchange between V4 and R1. V4 again instead of walking away, appears to push R1 away from him and makes contact with the resident's chest and hands. V4 continues to make motions with his hands and points in the direction down the hall in an effort to tell the resident to go back to his room. The whole exchange lasted over 2 minutes whereupon the resident disappears from camera view and V4 returns to nursing station. On 7/19/25 at 3:30 PM, R1 said, a male nurse treated me like some dog. I asked him to go see what's going on with another female resident who kept screaming and screaming and she sounded like she was in a lot of pain, and no one was paying attention to her. I asked this male nurse to go help her and he shouts down the hall to me to quiet down and that it wasn't his patient and to go back to my room. This really upset me because he treated me like I was some mental patient, and this angered me. He kept arguing with me that it wasn't his patient and to stop telling him what to do. He motioned to me to come to him like I was some dog as if he wanted to fight me, so I did that and went over to him, but I didn't hit him or anything, but he was pointing his finger at me and kept motioning to me to get the hell away from him instead of addressing the situation. He pushed me away and that's when I think he hurt my chest, and I must have banged my elbow, but I was so angry that I can't really recall all the details. He's a nurse and should not treat patients this way so I told this when I was in the ER (emergency room.). R1 returned to the facility after treatment but expressed to staff the following day that he no longer felt safe and requested discharge against medical advice. R1 said he was being watched by V3 social worker and other staff and he was treated like an animal and wanted to go somewhere else instead where staff were kind. R1 stated R1 was trying to get another patient some help.On 7/18/25 at 3:30 PM, V3 (Social Service Director) said that he is involved in the orientation of new employees, but that part of his orientation does not include anything related to de-escalation of behaviors but more so a general summary of dementia and emphasis on elopement prevention. On 7/18/25 at 4:10 PM telephone interview, V4 (LPN) said that he did not have any physical contact with the resident and denied raising his voice to the resident. V4 said that R1 placed his chest against his chest and his arms were at his side and he tried to control himself. Surveyor asked what he meant by trying to control himself and asked if R1 made him angry, V4 said that he meant that he wanted to try to make the resident calm was what he meant to say but admits that he was unable to calm the resident down. Surveyor asked where his arms were when this altercation came about, V4 said that his arms were at his side all the time. Surveyor asked if he raised his voice, shout at the resident, or used any type of harsh language, V4 said that he told (R1) that the resident that was screaming was not his and that he had the resident to go back to his room numerous times, but the resident did not listen to him. V4 indicated he had past dementia training but not this current facility. V4