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	02/25/2026

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents dependent on life-sustaining medical equipment received the specialized respiratory care and continuous clinical monitoring essential to prevent life-threatening complications. during a total facility power loss. These failures affect all residents (R1-R15) who are ventilator dependent.This failure resulted in all ventilator department residents being sent to the hospital to maintain health and safety and placed R1-R15 at risk for Acute Respiratory Distress, Acute Respiratory Failure and Death.The Immediate Jeopardy began on [DATE] at 9:30PM when an area wide electrical power loss caused the facility generator to fail, and the emergency generator power did not activate as designed to backup the main building power source. All areas of the facility and electrical and medical devices requiring electrical power failed to continue to operate. The Facility Emergency Management Plan designed to mitigate these types of emergencies was not effectively activated and implemented and all ventilated residents were evacuated to the hospital. On February 17, 2026, at 2:02PM the facility administrator was notified of Immediate Jeopardy. The facility presented an acceptable removal plan on February 25, 2026, at 12:25PM. While the immediacy was removed on [DATE], the facility remains out of compliance at a level two due to additional time needed to evaluate the implementation and effectiveness of the plan of correction.Findings include:R1's care plan states that she is a [AGE] year-old female with diagnoses including, in part, Chronic Respiratory Failure and COPD.V1, Administrator stated on [DATE] at 9:26PM: The emergency backup generator failed to activate, resulting in a total loss of electrical power to the specialized ventilator unit. The facility remained without electrical power for 3 hours and 15 minutes, until power was restored on [DATE] at 12:41AM.V11 on [DATE] at 1:31PM stated that she documented in the EHR (Electronic Health Record) the final clinical assessment of R1's respiratory status, including ventilator settings and suctioning needs for R1. R1's care plan and POS (Physician's Order Sheets) stated that R1 required full mechanical ventilation via a tracheostomy.R1's EHR for [DATE]-1:31PM-[DATE] 12:05AM showed no clinical monitoring was documented for R1, the medical records contain no documented respiratory assessments, ventilator checks, or evidence of clinical monitoring for R1. V6 (RT) Respiratory Therapist on duty at the start of the power outage, failed to document any respiratory assessments, ventilator checks or clinical monitoring for R1. No documentations of assessments for R1 were able to be presented during the survey, when requested for the duration of the power outage and generator failure.Timeline of events of [DATE]The facility's clinical nursing status during the power failure was characterized by the following:Staffing: One (1) respiratory therapist on-site with documented competency to manage life-sustaining equipment for 14 ventilator-dependent and 6 tracheostomy residents. Nursing: The ventilator unit was staffed with 2 nurses (V7 and V8) and 2 nurse's aides. The Registered Nurse V8 (RN) on duty was working a consecutive double shift exceeding 14 hours per V8 and schedule for [DATE]. V8, RN on [DATE] at 4:18 PM with V1 administrator present said I remember that evening. the power went (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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	out and it was still light outside and was a couple hours into my shift, so maybe the power went out around 5 or 6 o'clock. I stayed there until 1 AM. We put the ventilators into the red outlets, and we watched all the patients' rooms. Surveyor asked, should the ventilators be plugged into the red outlets from the beginning?, V8 said he didn't know but that he switched the plugs from the regular outlets to the red emergency outlets. V8 went on to say that he focused on (R1) because she was on ventilator. Regarding nursing interventions for R1, V8 said, I didn't do anything to the ventilator patients, it's not my thing. There is nothing you can do but see if its warm in the facility since there's no air conditioning since it went out. V8 stated what he did as nursing interventions during the emergency outage, V8 said, Nothing happened except the power was all out and dark and I checked to see if she was breathing and if she was in distress. V8 stated regarding how this was conducted and where he documented his nursing actions, V8 said, I couldn't document at that time because there was no computer power and when I left it did not come back on until between 12 and 1 AM. V8 stated regarding any other actions he performed for any other residents he cared for, V8 said, I didn't monitor any other residents at the time. We didn't have a lot of staff and so you had to balance yourself. I focused mostly on R1.V7 on [DATE] at 2:55 PM, stated that, at the time of the outage said, The outage started approximately at 9-9:30PM. I was there until 2 AM because the paramedics came around 10:30 PM and they were questioning us, and we said that we have a ventilator unit. We noticed everything is dark on the ventilator and so the RT told me to bring oxygen cylinders. I did 4 or 5 patients, and I put ventilators [power] plugs into emergency outlets to the generator. The power came back around 1:15 -1:45 AM before I go home.Facility's undated policy/procedure titled Emergency Operations Plan during Loss of Electrical Power, with a Generator reads in part (but not limited to): Should battery on ventilator not continue operating when unplugged from electrical outlet, manual ventilation should be initiated via Ambu-bag located at each resident bedside. Ambu-bag should be connected to oxygen source liquid gas E-tank immediately. Nursing staff will continually assess residents during this period to assure their physical and emotional wellbeing. Respiratory staff will continually assess residents during this period to assure respiratory percentage and levels remain safe. As of [DATE] at 4:18PM V1 and V4 were not able to provide documented evidence that manual ventilation was initiated for R1 or the other ventilator-dependent residents once staff realized the red outlets were non-functional.V1 on [DATE] at 3:00PM stated R1 was removed from the facility on [DATE] and taken to the local hospital via ambulance. The hospital admission records shows R1 was admitted minutes prior to power restoration at the facility, after being in the facility since the power failed without documented evidence of respiratory monitoring or nursing interventionsXXX[DATE] R1's clinical laboratory tests upon admission to hospital from the facility showed elevated lactic acid levels (3.6 mmol/L) normal lab values levels are 0.5-2.2mmol/L. Elevated lactic acid levels in a clinical setting can be a medical marker used to identify tissue hypoxia and metabolic stress sustained during periods of respiratory compromise. Lactic acid is a byproduct of anaerobic metabolism that occurs when cells are deprived of oxygen. (retrieved from American Association of Respiratory care https://www.aarc.org/ 02/26)R1 expired in the hospital on [DATE] due to Chronic Respiratory Failure and Chronic Obstructive Pulmonary Disease as list on the death certificate. The facility presented an acceptable removal plan on February 25, 2026, at 12:25PM which was confirmed onsite by the surveyor by interview and record review. The removal plan included the following:-updated Emergency power outage plan.-updated staffing plan for emergencies-updated command list for Key personnel outlining responsibilities of responsible individuals.-created plan to monitor and track maintenance of life maintaining equipment.-QA tool to monitor and compliance.-facility reviewed and updated staffing plan

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F 0906 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. Based on interview and record review, the facility experienced a power failure related to an area wide power outage. The facility's backup generator failed to provide back up power for the facility as it is designed to do during a power outage. The facility failed to ensure the safety of all residents dependent on life-sustaining equipment related to inability to provide electricity to life sustaining devices during the power failure. The facility failed to document the generator was in working order by completed weekly testing and monthly testing under load to ensure the backup generators availability in an emergency. These failures resulted in an immediate jeopardy because the failure of the backup generator to properly function at the facility caused every resident dependent of life sustaining devices to be at risk for health and safety. This widespread power failure affected the entire facility including 14 ventilator-dependent residents dependent on life-sustaining equipment putting them at risk for acute respiratory distress and causing them to be sent to the hospital via ambulance.The Immediate Jeopardy began on 09/20/25 at 9:30PM when an area wide electrical power loss caused the facility generator to fail, and the emergency generator power did not activate as designed to backup the main building power source. All areas of the facility and electrical and medical devices requiring electrical power failed to continue to operate which included:-All residents on mechanical ventilators-All residents on tube feeding pumps-All residents utilizing air mattresses-All mechanical lifts-and other departmental functions using electricity.On February 17, 2026, at 2:02PM the facility administrator was notified of Immediate Jeopardy.The facility presented an acceptable removal plan on February 25, 2026, at 12:25PM. The removal of immediacy was validated onsite by the surveyor with interview and record review of steps taken by the facility to implement their Emergency Management Plan. While the immediacy was removed on 2/25/2026, the facility remains out of compliance at a level two due to additional time needed to evaluate the implementation and effectiveness of the plan of correction.Findings include:V1, Administrator on 02/09/26 3:18PM- stated On September 20, 2025, at 9:26 PM, the primary utility power failed. The facility's emergency generator did not engage. V1 said, I came to facility around 9:45PM or before 10PM and the door was already propped open due to V12 (Maintenance Director) opening it. The facility was all dark and I pulled out my emergency prep binder and contacted all the consultants to come in and we pulled out the binder with all the face sheets in case we needed to prepare for evacuation and called the local fire department that we may need to evacuate. I called the hospitals in the area to see if they could accept our patients in event of an evacuation. I confirmed that V12 (Maintenance Director) was working on the generator trying to trouble shoot it and he contacted the generator's contractor, and I gave direction to my team to send emails to families letting them know of the situation. I started with my ventilator patients and the fire chief already came into the building even before I got there. They (electric utility company) came out and they still needed a different team from (electric utility company) to come out because the current team didn't know how to manage the situation. The generator had not kicked in and so I made sure respiratory had attached liquid oxygen and we started this around 11:26 PM and carried the residents through the stairs and staff lit up the stairs flashlights. V1stated the root cause of the generator failure as, The gas tank wires that activated the generator burned out. The generator service company thinks what happened is that the tank that holds the gasoline may had condensation and caused the water and gas to mix and when it transported through the wire, that the mixture burned out the generator. V12 on 2/9/25: Maintenance Director agreed to provide any maintenance logs and testing along with the generator service company visit papers. Review of the facility's maintenance records at the time of the survey found no evidence of (continued on next page)

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F 0906 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	monthly load-bank testing or weekly generator inspections for the three months preceding the outage on 09/20/25.V12 on 02/09/26 at 10:14AM: Maintenance Director confirmed that the emergency outlets (Red Plugs) remained without power until a portable generator was sourced and connected at 12:41 AM on the following morning September 21, 2025.The facility's Emergency Operations Plan, Section 4.2, states: If a ventilator battery does not continue operating or power is lost, manual ventilation (Ambu-bagging) must be initiated immediately.V8, RN on 2/9/26 at 4:18 PM: stated he was working a double shift, having started at 7:00 AM and remaining on duty until 11:00 PM (and subsequently until 1:00 AM due to the outage). V8 stated that during this 16-hour period, he did not initiate manual ventilation or conduct specialized respiratory monitoring, stating, 'You had to balance yourself. I didn't do anything to the ventilator patient, it's not my thing.V8 on 02/09/2026 at 4:18 PM with (V1 administrator present), V8 (RN) said I remember that evening. the power went out and it was still light outside and was a couple hours into my shift so maybe 5 or 6 o'clock PM. I stayed there until 1 AM. We put the ventilators into the red outlets, and we watched all the patients' rooms., V8 said he didn't know if ventilators should be plugged into the red outlets but that he switched the plugs from the regular outlets to the red emergency outlets. V8 went on to say that he focused on (R1) because she was on ventilator. V8 stated regarding nursing interventions for R1, I didn't do anything to the ventilator patient, it's not my thing. There is nothing you can do but see if it's warm in the facility since there's no air conditioning since it went out. V8 stated regarding nursing interventions during the emergency situation, Nothing happened except with the power, and I checked to see if (R1) was breathing and if she's in distress. regarding why there was no documentation to show his nursing actions, V8 said, I couldn't document at that time because there was no computer power and when I left it did not come back between 12 and 1 AM. V8 stated regarding other actions taken for any other residents, No I didn't monitor any other residents at that time. We didn't have a lot of staff and so you had to balance yourself. I focused mostly on (R1).V7 on 2/9/2026 at 2:55 PM: confirmed the unit was in total darkness and that manual ventilation was not performed for any of the 14 ventilator dependent residents during the power outage. the nurse on duty at the time of the outage said, The outage started approximately at 9-9:30 (PM). I was there until 2 AM because the paramedics came around 10:30 PM and they asked us if we have a ventilator unit. Meanwhile we attached ventilators to the red emergency outlets. V7 could not verify if there was any power coming from the emergency outlets, V7 said, no all the lights went out, so I called V6 respiratory therapist and told her the light is not coming and everything is dark. We noticed everything is dark on the ventilator and so the RT told me to bring oxygen cylinders. I did 4 or 5 patients, and I put in plugs into emergency outlets to the generator. There was still no power and it was dark. The power came back around 1:15 -1:45 AM before I go home.On 2/11/26: A review of personnel files found that V8 (RN) lacked a documented competency evaluation for ventilator management or emergency respiratory procedures (Ambu-bagging).As of 2/11/26, V8's personnel file lacked a documented competency evaluation for management or emergency respiratory procedures (ambu-bagging)V13 on 2/11/2026 at 1:46 PM identified herself as being one of the nurses working on the eastern side of the ventilator floor and stated regarding where the backup batteries were stored for the ventilators in case of a power failure, V13 stated, I'm sorry, I don't know where they are, nobody told me.V14 on 2/11/2026 at 2:16 PM stated the other nurse on the ventilator floor was asked about the backup batteries for ventilators and stated, I also did not know where to find any backup batteries or where any were stored in case of ventilator battery failure.Facility's undated policy titled, Emergency Operations Plan- Loss of Electrical Power, with a Generator reads in part: Objective: Facility will assure that residents remain safe and comfortable in the (continued on next page)

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F 0906 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	unlikely event of a full power outage. Facility is equipped with an emergency generator set which will provide a minimum of 200 hours of emergency power prior to refueling. Procedure: Facility will prepare for a loss of electrical power, with a generator as follows: Upon loss of electrical power, Administrator will determine the likely time of power restoration by contacting Electric Utility Company. Administrator will contact CHUG to begin process of determining bed availability within the immediate area, should evacuation be needed. Nursing Functions: Non-ambulatory residents will remain on their units under close supervision. Nursing staff will ensure that all medical equipment and low air loss beds are energized by utilizing red emergency power plugs throughout the facility. Nursing staff will continually assess residents during this period to assure their physical and emotional wellbeing. Respiratory Functions: Non-ambulatory residents will remain on their units under close supervision by the respiratory therapist. Respiratory staff will ensure that all medical equipment and low air loss beds are energized by utilizing red emergency power plugs throughout the facility. Respiratory staff will continuously assess residents during this period to assure respiratory percentage and levels remain safe.The facility presented an acceptable removal of immediacy plan on February 25, 2026, at 12:25PM, which was validated by the surveyor through interview and record review of steps taken by the facility to implement their Emergency Management Plan. The removal plan included the following:-The facility has an emergency policy and procedure system in place on what to do if the facility's electrical system is affected. The policy was reviewed and revised on 02/17/2026-The emergency policy and procedure affecting the facility's electrical system is reviewed upon hire during orientation and educated on annually.