STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145111	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Extended Care Center	200 East Lake Street Elmhurst, IL 60126

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on interview and record review the facility failed to notify a resident's (R1) physician and representative after the resident had a change in condition requiring to be transferred to the hospital after a fall. This applies to 1 of 3 (R1) residents reviewed for change in condition. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease, dementia, age-related osteoporosis with recurrent pathological fracture, osteoarthritis, acquired absence of the right upper limb, abnormalities of gait and mobility, and muscle weakness. The EMR showed R1 was transferred to the hospital on 8/05/2024. On 8/27/2024 at 12:35 PM, V2 (Director of Nursing/DON) said R1 had a fall on 8/05/2024 at approximately 4 AM. V2 said when she arrived at the facility on 8/05/2024 at 8 AM she was informed that R1's daughter was visiting and called the emergency paramedics to have R1 transferred to the hospital at approximately 6 AM for further evaluation because R1 was complaining of generalized pain after her fell . V2 said V12 (Agency Registered Nurse/RN) was assigned to R1 when she fell . V2 said she investigated R1's fall incident and called V12 (Agency Registered Nurse/RN) because V12 did not document R1's fall incident nor her hospital transfer. V2 said V12 reported that she did not notify R1's physician and representative after R1 fell . V2 continued to say V12 also did not notify the physician of R1's hospital transfer. V2 said R1 was admitted to the hospital for multiple bilateral rib fractures related to her fall. V2 said she expects nurses to notify physicians and resident representatives when a resident has a change in condition including falls. On 8/29/2024 at 12:00 PM, V19 (Physician) said he was not notified of R1's fall and hospital transfer on 8/05/2024. V19 said he expects the nursing staff to notify him when a resident has a change in condition including falls to determine if the resident needs to be sent to the hospital for further evaluation. V19 said he should have been notified of R1's fall and of her acute pain after the fall. V12 (Agency RN) was not able to be reached for an interview during this survey. V12's untitled witness document dated 8/05/2024 did not show R1's physician and representative were notified of R1's fall incident. (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: 145111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER: Elmhurst Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 East Lake Street Elmhurst, IL 60126	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital records dated 8/06/2024 showed Family expressed concern over how the patient was being treated at the nursing facility, as nobody was notified after pt (patient) fall and per family, pt did not receive any medical attention afterwards. Family called 911 upon visiting pt. The facility's policy titled When to Call the Doctor-Protocol dated 1/14/2024 showed I. The physician caring for residents in the facility wants to respond in an appropriate and timely manner to acute changes in a resident's condition as indicated by the nursing staff, and to ensure continuity of care. A. The types of conditions which frequently arise are .10. Falls 11. Family concerns .II. It is the responsibility of the nursing staff to observe the change, make an assessment and notify the physician as indicated based on the assessment. The goal of this policy is to have nursing identify the urgency of the situation and determine when to make the call.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to follow its reporting abuse policy for a resident with an injury of unknown origin. This applies to 1 of 4 (R2) residents reviewed for injuries. The findings include: R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE] with multiple diagnoses including acute kidney failure, obstructive reflux uropathy, sepsis, hypotension, bilateral inguinal hernia, hepatomegaly, benign prostatic hyperplasia, constipation, pressure ulcers to right and left heel, congestive heart failure, urinary tract infection, and muscle disorder. R2's MDS (Minimum Data Set) dated 6/28/2024 showed R2 was severely cognitively impaired and dependent on facility staff for assistance with transfers and ADLs (Activities of Daily Living). On 8/27/2024 at 11:27 AM, V8 (Certified Nurse Assistant/CNA) and V10 (CNA) were asked to do a skin check on R2. R2 had dark purple pigmented bruises to his right inner arm and right lateral torso area that extended across his anterior chest area with faded greenish and yellow pigmentation. R2 was not able to be interviewed. V9 (Registered Nurse/RN) was then asked to assess and measure R2's bruises. V9 said R2's right lateral torso bruise measured approximately 22 cm (centimeters) in L (length) x 19 cm in W (width) and the right inner arm bruise measured approximately 15 cm L x 7 cm W. V9 said she was unable to measure R2's anterior chest bruise. V9 said R2's bruising was noted last week and was reported to the physician and V2 (Director of Nursing/DON). V8 (CNA) and V9 (RN) said R2 did not have a recent fall or incident. They continued to say R2 had the tendency to lean on his right side when in his chair and was receiving blood thinners which they believed possibly caused his injury. On 8/27/2024 at 8:30 AM, V20 (R2's Daughter) said she was notified of R2's bruise on 8/19/2024. V20 said V2 (DON) said the facility was going to investigate the cause of R2's injury. V20 said she was concerned because she still had not received an update from the facility regarding the cause of R2's bruise. On 8/28/2024 at 12:35 PM, V2 (DON) said she was notified of R2's right lower axillary bruise. V2 said R2 did not have any reported falls or incidents. V2 said R2's physician and family were notified. V2 said R2 had labs and x-rays which all resulted normal. V2 said she assessed R2's bruise and interviewed the staff involved with R2's care to try to determine the cause of the injury. V2 said she noticed R2 had the tendency to lean on his right side when in his recliner wheelchair and believed that possibly caused R2's injury. V2 said she was not aware she had to report R2's injury of unknown origin to the State Survey Agency. On 8/29/2024 at 11:00 AM, V1 (Administrator) said he was the abuse coordinator. V1 said he was aware that injuries of unknown origin had to be reported to the State Survey Agency. V1 said he was not aware of R2's injury. V1 said R2's injury was not reported to the State Survey Agency. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elmhurst Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 East Lake Street Elmhurst, IL 60126	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/2024 at 12:00 PM, V19 (Physician) said he was notified of R2's bruise and was concerned because R2 did not have any recent reported falls or incidents. V19 said R2 was at risk for bruising due to his age, fragile skin, and use of anticoagulants. V19 said he was the facility's medical director and expected the facility to follow their abuse investigation policy for reporting incidents of residents with injuries of unknown cause. The facility's policy titled Reporting Abuse to State Agencies dated 1/05/2024 showed Procedure: 1. Should a substantiated incident of mistreatment, neglect, injuries of an unknown source .the facility administrator, or his designee, will promptly notify the following agencies or persons, verbally or in writing of such incident. Incidents are to be reported immediately, but not later than 2 hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury, or not later than 24 hours if the events do not result in serious bodily injury. A. The State licensing/certification agency responsible for surveying/licensing the facility .

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to safely position a resident (R1) in bed during care and safely transfer the resident after a fall. This failure resulted in the resident falling out of bed and sustaining multiple rib fractures. The facility also failed to identify a resident's (R2) transfer status in the plan of care, safely transfer the resident, and apply a wheelchair positioning device for the resident with a known behavior of unsafely leaning to the side. This applies to 2 of 4 (R1 and R2) residents reviewed for safety. The findings include: 1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease, dementia, age-related osteoporosis with recurrent pathological fracture, osteoarthritis, acquired absence of the right upper limb, abnormalities of gait and mobility, and muscle weakness. R1's MDS (Minimum Data Set) dated 8/05/2024 showed R1 was cognitively intact and dependent on facility staff for assistance with bed mobility and toileting. The EMR showed R1 was transferred to the hospital on 8/05/2024 and was not readmitted to the facility. On 8/28/2024 at 3:00 PM, V11 (Certified Nurse Assistant/CNA) was interviewed regarding R1's fall incident on 8/05/2024. V11 said on 8/05/2024 at 4 AM she was going to render incontinence care to R1 in bed. V11 said she turned R1 on her right side away from her. V11 said she then turned away from R1 to gather incontinence supplies and left R1 unsupervised. V11 said R1 then fell out of bed on the floor. V11 continued to say she then immediately assisted R1 into a standing position and transferred her back to bed. V12 (Agency Registered Nurse/RN) was not able to be reached for an interview during this survey. V12's untitled witness document dated 8/05/2024 said she was notified by V11 (CNA) that R1 fell out of bed while receiving incontinence care. The statement said R1 was in bed when she went to assess R1 after the fall. The statement continued to say R1 verbalized generalized pain and had sustained a skin tear to the left elbow, an abrasion to the left shin, and a bruise to the right knee. On 8/27/2024 at 12:35 PM, V2 (Director of Nursing/DON) said R1 was transferred to the hospital for further evaluation because she was complaining of acute generalized pain after her fall. V2 said the hospital informed the facility R1 had sustained multiple bilateral rib fractures. V2 said she expected the nursing staff to follow fall prevention precautions during bed mobility to ensure the safety of residents. V2 said V11 (CNA) should have not positioned R1 away from her nor should have left her unattended when she was rendering incontinence care. V2 continued to say V11 also should have not transferred R1 after she fell without having been assessed by the nurse. R1's imaging hospital records dated 8/05/2024 showed R1 sustained Right 6th-10th rib fracture deformities and left 9th-10th rib fracture deformities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's initial and final report titled Serious Injury Incident Report dated 8/05/2024 said R1 rolled out of bed when receiving incontinence care. The report said R1 was complaining of pain and was sent to the hospital and was treated for rib fractures. R1's Fall Risk Evaluation dated 5/03/2024 showed R1 was at risk for falls. On 8/28/2024 at 10:10 AM, V1 (Administrator) said the facility did not have policies regarding bed mobility and positioning. The facility's policy titled Fall Management Program dated 1/18/2024 showed Definition: Fall management program is an interdisciplinary quality improvement design to assist in providing individualized, person center-care and improving fall care process and outcomes through quality improvement tools and education. Purpose: to prevent and/or decrease the number of falls and reduce injuries resulting from falls. 2. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE] with multiple diagnoses including acute kidney failure, obstructive reflux uropathy, sepsis, hypotension, bilateral inguinal hernia, hepatomegaly, benign prostatic hyperplasia, constipation, pressure ulcers to right and left heel, congestive heart failure, and muscle disorder. R2's MDS (Minimum Data Set) dated 6/28/2024 showed R2 was severely cognitively impaired and dependent on facility staff for assistance with transfers and mobility. On 8/27/2024 at 11:27 AM, R2 was sitting in his reclining geriatric wheelchair. R2 did not have his wheelchair supportive arm device in place. V8 (CNA) and V10 (CNA) said they were going to transfer R2 to bed. V8 and V10 used a total mechanical lift machine to transfer R2. R2's legs were contracted in a fixed position and flexed towards his right side. R2 had a dressing to his right heel and bruising to his right inner arm and right lateral torso area extending to his anterior chest area. V9 (RN) came to R2's room to assess his bruises. V9 said R2 had a pressure ulcer to his right heel and his arm and torso bruising was noted last week. V8 and V9 said R2 did not have a recent fall or incident. They continued to say R2 had the tendency to lean on his right side when in his chair and was receiving blood thinners which they believed possibly caused the bruising. On 8/27/2024 at 1:50 PM, R2 was in the dining room sitting in his reclining geriatric wheelchair. R2 did not have his wheelchair positioning supportive arm device in place. On 8/28/2024 at 8:37 AM, R2 was in the dining room sitting in his reclining geriatric wheelchair. R2 did not have his wheelchair positioning supportive arm device in place. On 8/28/2024 at 11:55 AM, V9 (RN) was interviewed regarding R2's transfer status. V9 said she was not sure what was R2's transfer status. V9 looked in R2's EMR and said she was not able to find R2's transfer status. V9 then looked at the facility's posted transfer status list and said it did not show R2's transfer status. On 8/28/2024 at 4:30 PM, V8 (CNA) was interviewed regarding R2's transfer status. V8 said he was not sure what was R2's transfer status because he could not find it in R2's EMR nor on the facility's posted transfer status list. V8 said R2's transfer status varied, and he makes a judgment call daily when transferring R2. V8 said he sometimes transfers R2 quickly with one or two-person assistance and sometimes he uses the total mechanical lift by himself to transfer R2. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/28/2024 at 9:50 AM, V16 (Director of Rehab) said R2 was discharged from therapy on 7/10/2024 with a recommendation to continue to be transferred with the use of a total mechanical lift because of his weakness, foot wound, and lower leg contractures. On 8/29/2024 at 11:10 AM, V2 (DON) said R2 was observed leaning unsafely to his right side when in his chair. V2 said R2's bruise most likely occurred due to his poor trunk control and unsafe positioning. V2 said she expected the staff to ensure R2's wheelchair positioning arm device was in place to assist R2 be properly positioned and prevent him from sustaining any further injuries. V2 said R2's transfer status has always been total mechanical lift with a two-person assist. V2 said she reviewed R2's care plan and the facility's posted transfer status list and they did not indicate R2's transfer status. V2 said residents' care plans should identify their transfer status to ensure staff are aware on how to safely transfer residents. V2 said she expected staff to follow residents' transfer status and when using the total-mechanical lift a two-person assistance was required for safety. R2's 7/10/24 Physical Therapy/PT Discharge Summary report said R2 was dependent on transfers and required the use of a mechanical lift. R2's document titled Follow Up Question Report dated 8/28/2024 (during the survey) showed R2's transfer documentation from 7/29/2024 through 8/28/2024. The document showed R2's transfer support provided varied from one-person physical assistance and two-person physical assistance. The document continued to show R2's transfer self-performance also varied from total dependence, extensive assistance, and limited assistance. R2's care plan dated 8/28/2024 said R2 was at risk for bruising and injury because he favored his right side and leaned over on the right side of his wheelchair. The care plan showed an intervention to Place right side arm rest bolster on the chair. Check and reposition resident while in (reclining geriatric) chair as needed for comfort. R2's care plan continued to show R2 required the use of the mechanical device (lift) for safe transfers which was initiated on 8/28/2024 (during the survey). On 8/28/2024 at 10:10 AM, V1 said the facility did not have policies regarding bed mobility and positioning. The facility's policy titled (mechanical) Lift dated 1/04/2024 showed Purpose: A. To move a resident safely with as little physical effort as possible .