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	09/18/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure a resident's DNR (Do Not Resuscitate) choice was followed for 1 of 8 residents (R1) reviewed for improper nursing care in the sample of 9. The findings include: R1's Admission Record, printed by the facility on [DATE], showed she had diagnoses including sepsis, multiple sclerosis, shingles, dementia, a personal history of urinary tract infections, resistance to multiple antibiotics, and a stage IV pressure injury with a wound vac. The Admission Record does not list R1's Advanced Directive choice on the document. R1's Order Summary Report, printed by the facility on [DATE], showed an order dated [DATE] for DNR (Do Not Resuscitate). On [DATE] at 1:00 PM, V6 (Registered Nurse/RN) said she was the nurse working on [DATE] when R1 was found unresponsive. V6 said she called a code blue over the intercom. V6 said she was not sure if R1 was a DNR or a Full Code. V6 said CPR (cardiopulmonary resuscitation) was initiated by the team. V6 said she could not recall who else was in R1's room doing CPR. V6 said she did not document in her charting that CPR had been administered. V6 said CPR was performed for one-to-two minutes before staff realized R1 was a DNR. V6 said she called 911 and was getting the IV (intravenous line) supplies ready to start an IV on R1 when someone asked if R1 was really a Full Code. V6 said she looked in R1's electronic medical record and found out that she was a DNR. On [DATE] at 2:04 PM, V13 (Certified Nursing Assistant/CNA) said she was the CNA for R1 on [DATE] when she was found unresponsive. V13 said a staff member called code blue over the intercom so she ran to R1's room. V13 said some of nurses and the previous Director of Nursing started performing CPR on R1. V13 said the CNAs assisted with CPR to give the nurses a rest. V13 said one of the nurses were trying to get the defibrillator machine set up, however, she is not sure if the defibrillator was used on R1 because she did not see R1's body jump, like it does when someone is shocked. V13 said staff were doing all this and no one seemed to notice that R1 was a DNR. V13 said CPR was continued on R1 until the paramedics arrived. V13 said the facility did not follow R1 or her family's wishes. On [DATE] at 2:45 PM, V2 (Director of Nursing) said the incident with R1 happened before she started working at the facility. V2 said she heard about the incident after she started at the facility. V2 said it is important to follow the residents' advanced directives because that is the residents' wishes. It is their right. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's POLST form (Practitioner Order for Life-Sustaining Treatment) dated [DATE] showed No CPR: Do Not Attempt Resuscitation (DNAR). R1's Progress Note dated [DATE] showed Patient was sleepy this morning. Ate only less than 25% .Seen again sleeping at 12 o'clock round, not in any distress. At 13:08 (1:08 PM) went to room with med, found patient unresponsive, no heart, no respiration. 911 was called. Patient is DNR. Pronounced death at 13:25 (1:25 PM) . The facility's [DATE] policy and procedure titled Advance Directives showed I. It is the policy of the Center (facility) to request executed copies of all advance directives for all residents at the time of their admission .II. The term advance directive means a written instruction, such as a living will, or health care power of attorney as recognized by Illinois State law and relating to the provision of such care when the individual is physically or mentally disabled . IV. The Center shall maintain such advance directives in the medical record (legal section) of the resident and refer to the resident's directive during the resident's entire stay at the Center, regardless of their status at the facility .VIII. The POLST form is executed and utilized in the facility per Illinois guidelines. Family is educated on the form upon admission and reviewed in care plans.

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure a resident was assessed after a fall, the assessment was documented, an incident report was filled out, and post-fall monitoring was completed for 1 of 8 residents (R8) reviewed for improper nursing care in the sample of 8. The findings include: R8's Admission Record, printed by the facility on 9/18/24, showed he had diagnoses including hydrocephalus (a condition in which an accumulation of cerebrospinal fluid occurs within the brain. This typically causes increased pressure inside the skull. Older people may have headaches, double vision, poor balance, urinary incontinence, personality changes, or mental impairment), dementia, and major depressive disorder. R8's facility assessment dated [DATE] showed he needed supervision or touching assistance for toileting, lower body dressing, and transfers. The assessment showed R8 was always incontinent of bowel and bladder. R8's care plan initiated on 7/2/24 showed he was at risk for falls. R8's Fall Risk Evaluation dated 7/1/24 showed he was a high risk for falls. R8's Progress Notes from 9/13/24 showed no fall documentation or assessment related to a fall for R8. On 9/18/24 at 12:38 PM, V10 (Certified Nursing Assistant/CNA) said R8 had a fall last Friday (9/13/24) in the morning that was not reported. V10 said he was in R8's room doing AM cares. V10 said he (V10) went into R8's bathroom to grab a washcloth to wipe R8's face and he heard a thud and went out to see what happened. V10 said R8 had been sitting in his wheelchair when he went into the bathroom to grab the washcloth and when he came back out, R8 had fallen backward in his wheelchair. V10 said he got V14 (Licensed Practical Nurse/LPN). V10 said V14 checked R8 and there were no injuries. V10 said V14 said R8 was okay, and he did not want to do a report. V10 said when R8 was on the floor, his head was on the floor, so it looked like he hit his head. On 9/18/24 at 12:43 PM, V2 (Director of Nursing/DON) was asked about R8's fall. V2 said she is not aware of any fall for R8 on 9/13/24. At 1:17 PM, V2 said she spoke with V10. V2 said the incident happened and it was not reported. V2 said she reviewed R8's progress notes and V14 did document that R8 was stable. V2 said that is not acceptable. V2 said R8 could have had a concussion, a brain bleed, or a change in his mental status. At 2:40 PM, V2 said there was no incident report filled out for R8's fall on 9/13/24. V2 said she spoke with V14, and he said he checked R8, and he (R8) did not have any injuries so V14 said he did not fill out the incident report. V2 said V14 should have done a full assessment on R8 and document the assessment. V2 said V14 should have updated R8's doctor and Power of Attorney, initiate neurological checks and continue to monitor R8. V2 said it is important to document an assessment and fill out an incident report so the staff can continue to monitor the resident. V2 looked in R8's electronic medical record with this surveyor and verified that no assessments or neurological checks were done on R8 after his fall on 9/13/24. On 9/18/24 at 1:59 PM, this surveyor left a message on V14's voicemail to please return call. No return call was received prior to exiting the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 1/18/2024 policy and procedure titled Fall Management Program showed 5. Immediate response to resident who fall(s). Careful Assessment, evaluation, and investigation along with immediate intervention to identify risk to prevent future incident. 6. Incident Report is under Risk Management in PCC. It is a complete incident summary that includes reason for the fall; time and place where the fall occurred; injuries observed, pain level and mental status; predisposing factors; witnesses; and interventions to prevent future fall. The undated Fall Protocol, provided by V2 on 9/18/24 showed When a fall occurs in a nursing home, it is crucial for nurses to act quickly and effectively to ensure the safety and health of the residents involved. The document showed step-by-step protocol that nurses should follow including: 1. Assess the situation immediately making sure the area is safe for both the nurse and the resident. Check for injuries including fractures, bruises, or signs of head injury. 2. Provide First Aid. 3. Evaluate Physical Condition: Vital signs, neurological assessment. 4. Document the Incident by completing an incident report detailing the circumstances of the fall, time, location, what the resident was doing before the fall, and ay observed injuries. Update the resident's medical record with relevant observations, assessments, and actions taken. 5. Notify relevant Parties including a physician and the resident's family. 6. Reassess and Modify Care Plan. 7. Implement Fall Prevention Measures. 8. Monitor the resident for any delayed symptoms, as some injuries may not present immediately. Ensure follow-up assessments and interventions are scheduled.