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	05/09/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on interview and record review, the facility failed to provide written documentation of residents' transfer or discharge from the facility. This applies to 4 of 4 residents (R1, R2, R3, R4) reviewed for inappropriate discharges in a sample of 4. The findings include: 1. R1's face sheet showed he was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, hydronephrosis, Stage 3 chronic kidney disease, dementia, unsteadiness on feet, disorders of the muscle, alcohol abuse, hypertension, and hyperlipidemia. R1 was transferred to the hospital and discharged from the facility on April 16, 2025. On May 8, 2025 at 2:43 PM, V8 (Family Member) said she did not want R1 to be discharged from the facility but upon transfer to the ER (emergency room) on April 16, 2025, was told he would not be allowed to return. V8 said she was in the process of having R1 transferred to a different facility and did not want him sent to the hospital. V8 said she would have wanted R1 to return to the facility to wait for placement at another facility instead of keeping R1 in the hospital to wait to be accepted to a different facility. On May 8, 2025 at 3:30 PM, V2 (DON/Director of Nursing) said R1 was discharged from the facility on April 16, 2025 due to behaviors. V2 said R1 was not allowed to come back to the facility due to his behaviors. V2 said he did not give R1 or his representative an involuntary discharge notice, involuntary judiciary petition, or written notice of a bed hold. V2 said he was not aware he needed to do so, as he was new to the facility. V2 said the nurses transferring the residents should provide the necessary written documentation to the resident. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 8, 2025 at 11:42 AM, V3 (CEO/Chief Executive Officer) said they were not able to take R1 back because of his psychotic behaviors. V3 said he was not appropriate for a skilled nursing facility level of care and needed more behavioral health care. V3 said she denied him because another resident complained of feeling unsafe and because they were not equipped to able to manage his behaviors while he was in the facility. V3 said they did not give R1 or the representative the involuntary discharge notice, involuntary judiciary petition, and was unable to find written documentation of the bed hold notification. V3 said the bed hold policy was only provided and reviewed with the residents upon admission. R1's progress notes showed the following: On April 16, 2025 11:26 PM, V2 wrote, Called [Name] (POA/Power of Attorney) when Assigned RN (Registered Nurse) informed writer. Addressed her concern that Assigned RN did not have to call 911 to send resident to ED (Emergency Department) since she only lives 2-3 minutes away. She also addressed that her family was at the facility during dinner time and resident was alright. POA also addressed her concern that a facility was waiting for resident to be admitted and just waiting for that referral to be approved. POA also informed writer multiple times regarding the hospital bills that they have to address to. On April 16, 2025 at 11:38 PM, Resident up around 8:30 PM started walking in the hallway and cross the room into the other female resident's room, urinated on floor in the resident's room, assisted resident with 2 assist to come out of female resident's room, resident agitated and started walking through the end of hallway trying to push the door. Entered to another resident's room took banana and trying to sleep in other resident's room bought out with difficulty with 2 assist during the time resident hit the CNA (Certified Nurse Assistant) as was agitated and was combative to come out of the room. Resident bought to room with 2 assist and assisted nursing station, resident wouldn't sit at one place then assisted back to bed trying to hit another CNA, so called 911 as per MD (Medical Doctor) order to send ER (emergency room) for further eval for combative behavior. DON (Director of Nursing) notified, daughter notified was not happy and started screaming at the writer and said you couldn't wait until morning to send him out. DON made aware. The facility was unable to provide written documentation provided to R1 or R1's representative. 2. R2's face sheet showed she was admitted to the facility on [DATE] with diagnoses including venous insufficiency, vascular dementia, obsessive-compulsive disorder, anxiety, gastro-esophageal reflux disease, osteoporosis, depression, hypertension, weakness, and dysphagia. R2 was transferred to the hospital on May 8, 2025. R2's EMR showed a progress note on May 8, 2025 at 8:33 AM, which documented the following Around 8:30 am noted resident lethargic, increased perspiration. Resident confused, verbally responsive .Resident POA (Power of Attorney) Daughter [Name] was informed and she agreed to send resident to ER. Resident was transfer to [Name] Hospital ER around 9 am at stable condition by [Company Name] ambulance. Report was given. DON informed. On May 8, 2025 at 1:08 PM, V6 (LPN/Licensed Practical Nurse) said she had transferred R2 to the hospital. V6 said she had given the paramedics copies of the face sheet and the medication list. V6 said she did not give R2 or her representative the written notice of bed hold as it was not her job title and she had never done it. V6 said possibly V2 (DON) would give the resident the document. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 8, 2025, the facility was unable to provide a copy of the written notice of bed hold given to the resident or representative. 3. R3's face sheet showed he was admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer, anemia, hyperlipidemia, peptic ulcer, low back pain, chronic kidney disease, history of falling, and spinal stenosis. R3's EMR showed a progress note on March 27, 2025 at 4:26 PM, which documented the following, Upon further discussion with [Name] NP (Nurse Practitioner) and Administrator, it was best for resident to be transferred to acute care hospital for further care of his wounds. Assigned RN was informed and was able to transfer patient. On May 8, 2025 at 1:08 PM, V6 said she transferred R3 to the hospital and did not give R3 or his representative the written notice of bed hold. On May 8, 2025, the facility was unable to provide a copy of the written notice of bed hold given to the resident or representative. 4. R4's face sheet showed she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, hypothyroidism, depression, adult failure to thrive, dysphagia, type 2 diabetes mellitus, bipolar disorder, and anorexia nervosa. R4's EMR showed a progress note on at 5:15 PM, the progress note showed, . Resident has midline on LUE (Left Upper Extremity) patent, left hand noted swollen elevated on pillows, cholecystostomy tube with 10 ML (Milliliters) output with resistance noted during flushing MD (Name) and 911 called @ 9.17 PM with ETA (Estimated Time of Arrival) of 5 to 7 minutes. POA notified @ 5.18 PM approximately. paramedics staff arrived @ 5.17 PM, all required documents required for transfer along with report provided to paramedics. paramedics left facility @ 5.26 PM. DON notified. On May 8, 2025 at 1 PM, V5 (RN/Registered Nurse) said when she sends the residents to the hospital, she gives the paramedics two face sheets, the advanced directive, and the medication list. V5 said she calls the POA and notifies them of the transfer. V5 said residents are allowed to return to the facility but if their care cannot be managed at the facility, they could not accept the resident. V5 said for example, if the resident required a psych unit, the facility does not accept them back. V5 said the admission coordinator and the social services team gets the doctors from the hospital. V5 said the bed hold notice should be given to the resident by the social worker since nursing does not deal with the bed hold policy. On May 8, 2025, the facility was unable to provide a copy of the written notice of bed hold given to the resident or representative. The facility's Bed Hold policy dated January 4, 2024 showed Medicaid residents properly admitted , have a right to return to the facility to the first available bed after a hospital transfer .If there is not a return, written notification will be provided with the reason for non-admittance and appeal rights and contract determination. The facility's Discharge Policy dated January 4, 2023 showed The resident, physician, representative will be notified of discharge.