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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145111 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>10/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Elmhurst Extended Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 East Lake Street<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</b></p> <p>Based on observation, interview, and record review, the facility failed to treat two residents (R13,R20) with dignity. This applies to 2 residents outside of the sample reviewed for dignity.</p> <p>The findings include:</p> <p>1) R13's electronic face sheet printed on 10/10/24 showed R13 has diagnoses including but not limited to dementia without behaviors, bipolar disorder, type 2 diabetes, and major depressive disorder.</p> <p>R13's facility assessment dated [DATE] showed R13 has severe cognitive impairment.</p> <p>On 10/9/24 at 1:36PM, V5 and V13 (Certified Nursing Assistants) provided incontinence care to R13 in the bathroom. V13 removed R13's incontinence brief and stated, Oh, she's pooping while R13 was in the standing mechanical lift. V5 then handed V13 the trash can and stated, Here, put this under her in case she goes more. V5 placed the garbage can underneath R13 while she was standing in the lift and continued providing incontinence care. V13 stated she is unsure of why they did not put R13 on the toilet and could not state why she put the trash can underneath of R13. V13 stated she could see how this would be a dignity concern as she would not want a garbage can placed under her while she was having a bowel movement. V13 then stated, Oh well, at least I know better for next time.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, It is absolutely unacceptable to place a trash can underneath a resident when they should be providing toileting assistance. There is no reason why you would place a trash can under a resident for any reason unless it was an emergency. The aides should have placed R13 onto the toilet so that she could have a bowel movement in a dignified manner. These residents are already vulnerable as they have low cognitive functioning, and this specific practice is degrading.</p> <p>The Illinois Long-Term Care Ombudsman Program Residents' Right for People in Long-Term Care Facilities dated 11/18 showed, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.</p> <p>2) R20's electronic face sheet printed on 10/10/24 showed R20 has diagnoses including but not limited to dementia, encephalopathy, dysphagia, and altered mental status.</p> <p>R20's facility assessment dated [DATE] showed R20 has severe cognitive impairment.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 10/8/24 at 12:36PM, R20's meal tray was positioned across the table from him. R20 then pulled his tray over in front of him and began drinking the water off his tray. V14 (Restorative Director) took R20's water out of his hand and pushed his meal tray out of his reach. R20 stated, I'm very hungry and V14 stated, We will feed you soon, but you can't have your tray right now and turned around to feed another resident. R20 then picked up a paper towel roll and was attempting to drink from it stating, I'm so thirsty.</p> <p>On 10/9/24 at 1:28PM, R20 was waiting for his lunch meal (all other residents on the unit were served lunch between 12:15-12:30PM). V15 (Registered Nurse) went and retrieved R20's meal tray and stated, He can't eat until we are ready to feed him because he will make a big mess and just put his hands in his food. It's just easier when we feed him.</p> <p>On 10/10/24 at 10:25AM, V2 stated, All of our residents should be encouraged to be as independent as possible. If (R20) has an issue getting his food to his mouth or using his silverware, then we should be providing adaptive equipment for him and attempting to let him use it. There is no reason why he should have had to wait for his meals just because staff were busy. They were in the dining room and able to supervise him. This is definitely a dignity concern as he had to watch all of the other residents receive their meals before he was allowed to get his.</p> |   |  |

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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41639</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 residents (R27 &amp; R26) were free from restraints. This applies to 1 of 1 residents (R27) reviewed for restraints in the sample of 16 and 1 resident (R26) outside of the sample.</p> <p>The findings include:</p> <p>1) R27's electronic face sheet printed on 10/10/24 showed R27 has diagnoses including but not limited to hydrocephalus, hypertension, mood disorder, dementia with behaviors, and major depressive disorder.</p> <p>R27's facility assessment dated [DATE] showed R27 has severe cognitive impairment and does not utilize any restraints.</p> <p>On 10/8/24 at 11:10AM, V18 (Certified Nursing Assistant-CNA) removed R27's foot pedals off his wheelchair, pushed him up to the dining room table and locked both of his wheels. V18 stated R27's behavior is a little unpredictable so that's why he moved him over to the table and locked his wheelchair. V18 stated R27 has been a little more active today &amp; is a fall risk &amp; tries to stand on his own. R27 was trying to move his wheelchair backwards and was unable to do so due to his wheelchair being locked. R27 was then tipping his wheelchair due to becoming frustrated that he could not move his chair independently.</p> <p>On 10/8/24 at 12:08PM, R27 was sitting near the exit door near the dining room. V15 (Licensed Practical Nurse) moved R27 away from the exit door, pushed him over to the table and locked both of his wheels. Again, R27 attempted to move his wheelchair away from the table and was unable to do so.</p> <p>On 10/8/24 at 1:30PM, V15 pulled R27 away from the table, provided him with a nutritional supplement, and then pushed him back up to table and locked both wheels on his wheelchair. V15 stated if R27 does not have his wheelchair locked he will be all over the unit and they are unable to keep track of him.</p> <p>On 10/9/24 at 11:06AM, R27 was sitting at the dining room table with both of his wheels locked on his wheelchair. V13 (CNA) asked R27 to unlock the wheels on his wheelchair and R27 was unable to comprehend what V13 was asking him to do and was unable to unlock the wheels of his wheelchair. V13 stated R27's wheels remain locked because he moves around the unit too much and they need to keep all the residents in one space.</p> <p>2) R26's electronic face sheet printed on 10/10/24 showed R26 has diagnoses including but not limited to Alzheimer's disease, lack of coordination, altered mental status, dementia with behaviors, and cognitive communication deficit.</p> <p>R26's facility assessment dated [DATE] showed R26 has mild cognitive impairment; however, throughout the course of the survey, R26 was unable to be interviewed due to cognitive impairment.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 10/8/24 at 12:34PM, R26 was pushed up to the table in his wheelchair with both brakes locked. R26 was pushing back from the table and unable to move due to his wheelchair being locked. R26 continued to try to remove himself from the table and was unable to do so.</p> <p>On 10/8/24 at 1:27PM, R26 was again attempting to move his wheelchair away from the table and was unable to do so due to both wheels being locked.</p> <p>On 10/9/24 at 9:28AM, R26 was at the dining room table and was attempting to push back from the table to pick up a piece of an activity he had dropped. R26 was unable to move his wheelchair due to both wheels being locked.</p> <p>On 10/9/24 at 11:01AM, R26 stated, I can't move, help me to move so I can go somewhere. R26 was attempting to move his wheelchair forward and was unable to do so due to both wheels being locked.</p> <p>On 10/9/24 at 11:06AM, V13 asked R26 to unlock the wheels on his wheelchair. R26 stated, Ok and then proceeded to play with the wheels on his chair and was unable to unlock the wheels after several requests by V13. V13 stated she is unsure if R26 can unlock his wheelchair but stated it's good because otherwise he will be all over the unit if he's not kept in one place.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, If a resident is placed in a position and held there then that is considered a restraint because they are not able to move independently. If (R26) and (R27) are attempting to move their wheelchair then staff should unlock them and allow them to move around. We can't keep residents in one area just for our convenience.</p> <p>The facility's policy titled, Physical and Chemical Restraints dated 1/4/24 showed, I. It shall be the policy of this facility to discourage the use of physical and chemical restraints for the purpose of discipline or convenience and that are not required to treat the resident's medical symptoms. II. A Physical Restraint is defined as any manual method, physical or mechanical device-material or equipment (attached or adjacent to the resident's body) that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body .</p> |   |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</b></p> <p>Based on observation, interview, and record review, the facility failed to provide timely incontinence care to 1 resident (R26) outside of the sample reviewed for activities of daily living.</p> <p>The findings include:</p> <p>R26's electronic face sheet printed on 10/10/24 showed R26 has diagnoses including but not limited to Alzheimer's disease, lack of coordination, altered mental status, dementia with behaviors, and cognitive communication deficit.</p> <p>R26's facility assessment dated [DATE] showed R26 is always incontinent of bladder.</p> <p>On 10/8/24 at 1:35PM, V18 (Certified Nursing Assistant-CNA) was notified by surveyor that R26's pants appeared wet. V18 and V13 (CNA) provided incontinent care to R26. V18 stated R26 was toileted at approximately 9:30AM this morning but hasn't been checked since then. R26 was placed in a standing mechanical lift and when he was lifted out of the wheelchair, the back of R26's pants were saturated with strong smelling urine and his wheelchair seat was wet with urine. V18 removed R26's incontinence brief that was saturated with urine. V18 laughed and stated, Wow, I guess he really was wet. V18 then continued incontinence care and placed a clean sheet over R26's wheelchair seat. V18 stated he placed the sheet there so that if he gets too busy it'll be easier to see if (R26) soiled himself again.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, All residents should be checked and changed every 2 hours and as needed. (R26) is one of the residents who cannot tell you if they need to go to the bathroom, so we must be especially diligent with that population and ensure we are checking them every time we encounter them. If staff are interacting with (R26) then they should be asking him if he needs any of his basic needs which includes toileting assistance. By allowing (R26) to sit in his urine for an extended period of time, staff are increasing the likelihood of an infection.</p> <p>The facility's policy titled, Incontinence and Catheter Management dated 1/4/24 showed, I. Policy: In accordance with regulatory requirements and professional practice standards the facility will ensure that: B. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible .</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175</b></p> <p>Based on observation, interview, and record review, the facility failed to identify a pressure injury prior to becoming unstageable, failed to implement offloading, and failed to develop and implement a care plan after the development of pressure ulcers for 1 of 5 residents (R14) reviewed for pressure in the sample of 16.</p> <p>This failure resulted in R14 developing two unstageable pressure injuries, one to each heel.</p> <p>The findings include:</p> <p>R14's face sheet showed a [AGE] year old female admitted to the facility on [DATE] from a local hospital.</p> <p>R14's 6/7/24 history and physical showed she was admitted post fall to a local hospital with a right distal femur fracture and surgical repair. R14 had significant weakness and deconditioning. This note showed no skin lesions and incision sites to the right hip and knee.</p> <p>On 10/08/24 at 10:19 AM, R14 was in her room in a wheelchair barefoot. There were blue protective boots on a chair in the room. R14's feet rested on the bottom metal bar of the bedside table in front of her. R14's feet were dependent and purple in color.</p> <p>At 1:06 PM, R14 was eating in her room. Her feet remained uncovered and on the table legs.</p> <p>On 10/09/24 at 10:21 AM, R14 was in a wheelchair attending the resident council meeting. R14's feet were bare, in a dependent position and purple in color.</p> <p>On 10/09/24 at 12:22 PM, V6 wound doctor said R14's heel wounds were pressure injuries and the other wounds were vascular. V6 said of course he'd expect offloading to be part of her interventions.</p> <p>R14's medical record active orders dated 10/9/24 documents, Heel protectors on bilateral lower extremities every shift, start date: 8/20/2024.</p> <p>On 10/10/24 at 10:10 AM, V4 Registered Nurse (RN) said on 6/24/24 she changed R14's right heel dressing as it was dirty. V4 was unable to explain why there was a dressing there, what soiled it, and the rationale for it's replacement. V4 said somebody put a dressing there (to the right heel) and it was dirty so I changed it. V4 then said the skin was intact. It was there for protection. V4 was unable to locate wound assessments for R14's right and left heel wounds prior to the physician assessment on 6/26/24. V4 said somebody must have seen something for the wound doctor to look at her heels. If there's a new area you are supposed to do a risk management note-do wound assessments, measurements. I put them on the wound list . I think the night nurse, V17, told me they found something new and asked me to put R14 on the wound list. At some point someone told me about both wounds and I put her on the wound list. V17 should have done some kind of note/assessment and get a treatment order from the doctor. We can put interventions in place. It's important to put interventions in place and get treatment orders to prevent further deterioration of wound. An initial assessment is important to have a baseline for comparison. V6 wound doctor did R14's first wound assessments on 6/26/24.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>On 10/10/24 at 11:26 AM, V2 Director of Nursing (DON) said an initial wound assessment should be done by the primary nurse who identified a wound for best practice. The assessment should include the type of wound, measurements, maybe a photograph to make sure it's documented. The doctor should be notified. Interventions should be implemented and wound treatment orders should be obtained. Complications that may occur if this is not done include worsening of the wound, infection, advancement to sepsis and it can become a sentinel event. It's a liability issue. Residents here have multiple comorbidities to consider. It's a liability issue if they come in without a wound and develop one here.</p> <p>R14's 6/5/24 admission skin assessment showed no pressure injuries to her heels.</p> <p>R14's 6/5/24 pressure injury risk assessment showed she was at risk for developing a pressure injury.</p> <p>R14's 6/24/24 health status note authored by V4 RN showed a dressing was applied to the right heel as it was soiled. This note showed R14 was at the facility for skilled rehab post hospitalization after a fall with right femur fracture.</p> <p>R14's 6/25/24 6:00 AM health status note authored by R17 nurse showed surgical sites to the right hip and knee were healed and a wound treatment was done to both heels.</p> <p>As of 6/25/24 at 6:00 AM, R14's medical record had no documented assessment of either heel wound.</p> <p>R14's 6/26/24 wound physician initial wound evaluation showed an unstageable (due to necrosis) pressure injury to the right and left heels. The right heel wound measured 3.2 centimeters (cm) X 2.5 cm X depth not measureable due to the presence of nonviable tissue and necrosis. The left heel wound measured 1.8 cm X 1.4 cm X depth not measureable due to presence of nonviable tissue and necrosis. Debridement of the right heel was initiated but was stopped due to pain. The left heel was debrided. This note showed an additional right dorsal foot wound due to infection and a left leg wound due to infection. The physician note recommended to off-load the wounds and float heels while in bed.</p> <p>R14's June 2024 treatment administration record (TAR) showed wound treatment orders were initiated for the the right heel wound on 6/24/24.</p> <p>R14's June 2024 medication administration record (MAR) showed wound treatment orders for the left heel were not started until 6/27/24.</p> <p>R14's wound care plan (as of 10/10/24) had no mention of any pressure injuries and no interventions to offload pressure.</p> <p>(continued on next page)</p> |   |  |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few  | The facility's 1/4/24 Pressure Ulcer Prevention & Treat Policy showed residents with actual alterations in skin integrity will have a plan of care developed to address measures to promote rapid healing of the wound. Residents who have actual alteration in skin integrity will be assessed for need for further measures to aid in rapid healing of wounds. Assessment and characteristic of wound must be documented every other day during wound dressing changes. Documentation guidelines B. A problem (real or potential will be entered on the resident care plan and will include prevention/treatment measures. Any change in the skin integrity status of the resident will be documented in the progress notes, the physician will be notified, and the patient care plan will be updated. When there is a decubitus ulcer being treated, the skin integrity report sheet will be initiated and descriptive information will be completed weekly by the nurse. This information will include: the specific location of the decubitus, the stage and measurement of the decubitus, the presence/absence of odor, the presence/absence of drainage, color, amount, consistency, or any change in drainage since previous measurement, and the presence of granulation. |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41639</p> <p>Based on observation, interview, and record review the facility failed to use a gait belt to transfer a resident (R16) and failed to provide supervision during mealtimes for a resident with a diagnosis of dysphagia (R28). These failures apply to 2 of 4 residents (R16, R28) reviewed for safety and supervision in the sample of 16.</p> <p>The findings include:</p> <p>1) R16's electronic face sheet printed on 10/10/24 showed R16 has diagnoses including but not limited to osteoarthritis, dementia without behaviors, and dysphagia.</p> <p>R16's facility assessment dated [DATE] showed R16 has severe cognitive impairment, lower extremity impairment, and requires substantial assistance with transfers.</p> <p>R16's care plan dated 9/7/24 showed, (R16) has potential for pain/discomfort related to arthritis on the right knee .handle resident gently when repositioning and transferring, particularly if pain is related to joint problems.</p> <p>On 10/8/24 at 12:13PM, V13 (Certified Nursing Assistant-CNA) was attempting to have R16 stand in the bathroom with the use of the bar next to her toilet. R16 was unable to stand on her own. V13 obtained the standing mechanical lift and V18 (CNA) arrived in the room and stated, Here, I can just get her to stand on her own by myself. V18 then lifted R16 underneath her arms to stand at the bar. R16 was yelling My knee hurts! I can't stand! V18 then grabbed R16 under her arms and placed her on the toilet. R16 was yelling obscenities at V18 following the transfer. When 16 was finished, V18 lifted her under her arms again and R16 was unable to fully stand up. V18 then used his back to push on R16's back to hold her steady while he pulled up her pants. Throughout the remainder of the transfer, R16 continued yelling at V18 that he didn't know what he was doing.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, Any resident that requires assistance with transfers should have a gait belt applied to them. The gait belt is supposed to provide additional support to the resident while also ensuring that it is a safe transfer for both the resident and the staff member. (V18) is lucky that the transfer didn't end up in an injury for both him and the resident.</p> <p>The facility's policy titled, Gait Belt for Transfer dated 10/20/23 showed, I. Purpose: To ensure resident and staff safety during ambulating and transferring .</p> <p>36186</p> <p>2. The facility face sheet for R28 shows diagnoses to include type 2 diabetes mellitus, subarachnoid hemorrhage, and chronic kidney disease. The Physician order sheet dated October 2024 for R28 shows an order for maintain aspiration precautions during meal and drinking fluid was obtained on October 3, 2024.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 10/8/2024 at 1:40 PM, R28 was observed lying in bed with his lunch tray in front of him. R28 was alone in his room.</p> <p>On 10/9/2024 at 1:00 PM, R28 was observed alone in his room with his lunch tray in front of him. No staff were observed near R28's room or entering his room to check on him.</p> <p>On 10/9/2024 at 1:20 PM, V4 Registered Nurse said R28 rarely eats his meals, he mostly eats what his wife brings him. When meal trays are passed to the rooms, the Certified Nursing Assistants (CNA) are to be monitoring the residents.</p> <p>On 10/10/2024 at 10:17 AM, V5 CNA said if a resident needs help with feeding we stay and assist them after bringing them their meal tray. V5 said residents on aspiration precautions should be monitored while eating. V5 said he doesn't usually work on this unit and was not familiar with how R28 eats his meals.</p> <p>On 10/9/2024 at 12:50 PM, V2 Director of Nursing said if a resident is on aspiration precautions, they should be observed while eating. V2 said R28 refuses to get up for meals, refuses a speech evaluation and refused to have a diet other than a regular diet. V2 said his wife comes and helps him at mealtimes.</p> <p>The nursing progress note dated 10/3/2024 for R28 shows the resident was not compliant with nectar thick liquids and had refused his speech therapy referral. The hospice staff were notified and an order for aspiration precautions was obtained.</p> <p>The care plan for R28 dated 8/11/2024 for his diet shows no interventions of aspiration precautions in place for him.</p> <p>The facility policy for aspiration precautions dated 1/4/2024 shows to establish guidelines that minimize the risk of aspiration in patients with swallowing difficulties, ensuring their safety, and promoting optimal health outcomes. Supervision: patients will be supervised during meals and snacks by trained staff to monitor for signs of aspiration or distress.</p> |   |  |

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| <p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</b></p> <p>Based on interview and record review, the facility failed to identify a significant weight loss, failed to notify a resident's physician and/or dietician for a significant weight loss, failed to develop care plan interventions to address a resident's significant weight loss. These failures apply to 1 of 2 residents (R27) reviewed for nutrition in the sample of 16.</p> <p>This resulted in R27 sustaining a 5.87% weight loss in 1 week.</p> <p>The findings include:</p> <p>R27's electronic face sheet printed on 10/10/24 showed R27 has diagnoses including but not limited to hydrocephalus, hypertension, mood disorder, dementia with behaviors, and major depressive disorder.</p> <p>R27's facility assessment dated [DATE] showed R27 has severe cognitive impairment and has experienced no weight loss.</p> <p>R27's weight log showed, 7/23/24 167lbs 8/1/24 157.2lbs. (5.87% weight loss in 1 week).</p> <p>R27's nursing progress notes and dietician notes showed no notification to either R27's physician or dietician regarding his significant weight loss of 5.87% in one week.</p> <p>R27's dietician note dated 8/15/24 showed, Add (supplement) twice daily and obtain weekly weights for 4 weeks.</p> <p>R27's care plan dated 9/29/24 showed, (R27) receives regular diet, regular texture, thin liquids. Diagnosis includes dementia, hypertension. Unplanned significant weight loss. R27's care plan showed no interventions related to R27's significant weight loss on 8/1/24.</p> <p>R27's medication administration record for August 2024 showed R27 was ordered a supplement twice daily on 8/15/24 and accepted the supplement for the remainder of the month.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, I haven't been here much more than a month so I'm not sure how things were handled previously. I currently monitor all the weights and meet with the dietician on a weekly basis to discuss any significant weight changes. (R27's) weight loss was a significant weight loss that should have been addressed immediately. The earlier you identify the weight loss, the better chance you have at getting the resident to gain the weight back. Now we are playing catch up with his weight loss because he was refusing so much of his meals. There's no reason why interventions should not have been put in place.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>On 10/10/24 at 12:15PM, V16 (dietician) stated, (R27) initially had a pretty significant weight loss but his weight has started to improve now that we started (appetite stimulant). He has started feeding himself and accepting help with meals. When his initial weight loss was identified, I ordered supplements for him, but he was refusing them. I wasn't notified right away about his weight loss; I think it was about 10 days to 2 weeks later that I found out about it and started the supplements right away. I also asked for the facility to reweigh him so that we could determine if it was a true weight loss or not. If they would have called me, I would have given them the order for the supplements.</p> <p>The facility's policy titled, Procedure and Timeline for Monthly Resident Weights dated 1/30/24 showed, III the dietician may continue tracking weekly weights for residents with a weight loss trend, or who are identified to be at increased nutritional risk. The nurse and dietician will communicate recommendations for changes to weight orders as appropriate .V. The names of residents who exceed the above guidelines after re-weighing will be shared with the IDT and charted on by the dietician identifying risks, barriers to weight maintenance and an appropriate nutrition intervention if applicable .</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36186</p> <p>Based on observation, interview, and record review the facility failed to label oxygen tubing. This applies to one of two residents (R31) reviewed for oxygen in the sample of 16.</p> <p>The findings include:</p> <p>The facility face sheet for R31 shows diagnoses to include chronic obstructive pulmonary disease, chronic respiratory failure, and chronic congestive heart failure. The Physician order sheet dated October 2024 shows an order for oxygen via nasal cannula if oxygen saturations are below 90%.</p> <p>On 10/8/2024 at 12:09 PM the oxygen tubing and humidifier for R31 was observed with no label indicating when the tubing was opened for use. On 10/9/2024 at 10:20 AM, R31's oxygen tubing and humidifier was still not labeled.</p> <p>On 10/9/2024 at 12:50 PM, V2 Director of Nursing (DON) said she expects the staff to label the oxygen tubing and humidifier to show when it was last changed. The oxygen tubing should be changed weekly.</p> <p>On 10/9/2024 at 1:20 PM, V4 Registered Nurse said the oxygen tubing and humidifier is to be changed weekly and it should be labeled with that date.</p> <p>The Medication Administration Record (MAR) dated October 2024 for R31 does not show any date or time the oxygen tubing was to be changed.</p> <p>The care plan dated 9/26/2024 for R31's oxygen shows no intervention regarding frequency of tubing changes.</p> <p>The facility policy for oxygen dated 1/4/2024 shows oxygen, cannula, mask and humidifier will be changed weekly and recorded with change date and initial.</p> |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41639</p> <p>Based on interview and record review, the facility failed to ensure a resident's (R27) psychotropic medication was used to treat a medical condition for 1 of 5 resident's reviewed for psychotropic medications in the sample of 16.</p> <p>The findings include:</p> <p>R27's electronic face sheet printed on 10/10/24 showed R27 has diagnoses including hydrocephalus, hypertension, mood disorder, dementia with behaviors, and major depressive disorder.</p> <p>R27's facility assessment dated [DATE] showed R27 has severe cognitive impairment.</p> <p>R27's physician's orders dated 7/23/24 showed, Seroquel 50mg (milligrams) every 12 hours as needed related to dementia with behaviors.</p> <p>R27's progress notes dated 7/28/24 showed, Resident noted with behavior. He is becoming more resistant to assistance and declining to follow command. Seroquel given with some relief.</p> <p>R27's progress notes dated 7/30/24 showed, Resident is alert to self and confused He refused to get up out of bed this morning. PRN (as needed) dose of Seroquel given. He allowed staff to dress him and agreed to get up.</p> <p>R27's progress notes dated 7/31/24 showed, Aide is attempting to toilet resident and he refuses to stand up. He is sitting in his wheelchair getting agitated with staff as we ask him to stand. PRN Seroquel given. Will attempt to toilet him again.</p> <p>R27's medication administration record for July 2024 showed R27 was given Seroquel 50mg on 7/28/24, 7/30/24, and 7/31/24.</p> <p>On 10/10/24 at 10:25AM, V2 (Director of Nursing) stated, Antipsychotic medications are to be given on an as needed basis only when residents are in danger of hurting themselves or others. If a resident declines to do what staff ask them to do then they should be left alone and reapproached by another staff member. (R27) not getting out of bed or not agreeing to go to the bathroom is not a reason to give a PRN medication, especially Seroquel. This was used for staff convenience, and they did not use any anti-pharmacological approaches from what I can see in the documentation prior to giving him the Seroquel.</p> <p>The facility's policy titled, Psychotropic Medication dated 1/4/24 showed, II. Psychotropic medications will not be administered for purposes of discipline or staff convenience and when not required to treat the resident's symptoms .</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>20042</p> <p>Based on Observation, Interview, and Record Review the facility failed to ensure a vaccine was refrigerated for 1 of 1 resident (R87) reviewed for medication storage in the sample of 16.</p> <p>The findings include:</p> <p>On 10/8/24 at 10:17 AM, observations were made of the first floor, west medication cart. In the top drawer of the medication cart was a pneumovax 23 syringe for R87. The pneumovax 23, 0.5 ml syringe was in a medication bottle that showed it was received on 9/7/24 and should be refrigerated. The bottle with the Pneumovax 23 inside of it was inside of a clear bag with blue lettering that stated Refrigerate. V11 RN (Registered Nurse) stated the Pneumovax 23 was not good anymore; it should have been refrigerated. V11 stated R87 was in the hospital for a procedure but was expected to return to the facility.</p> <p>On 10/8/24 at 10:45 AM, V2 DON (Director of Nursing) stated R87 went out for surgery so his medications were kept in the cart because he would be returning this week. V2 stated the Pneumovax 23 vaccine would lose potency if it was not refrigerated.</p> <p>The Physician Orders to be renewed for R87 dated 10/10/24 showed, Pneumovax 23 injectable 25mcg/0.5ml.</p> <p>The Face Sheet dated 10/10/24 for R87 showed diagnoses including acute kidney failure, atherosclerotic heart disease, atrial fibrillation, type 2 diabetes mellitus, hyperlipidemia, hypertension, chronic kidney disease, coronary artery dissection, heart failure, aortic valve stenosis, and anemia.</p> <p>The facility's Storage of Medication policy (1/4/24) showed, medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20042</p> <p>Based on observation, interview, and record review, the facility failed to ensure kitchen utensils were stored correctly and change gloves while handling equipment/utensils to prevent cross contamination. This failure has the potential to affect all 33 residents in the facility.</p> <p>The findings include:</p> <p>The Long-Term Care Facility Application for Medicare and Medicaid form dated 10/8/24 for the facility showed a census of 33 residents.</p> <p>On 10/8/24 at 11:51 AM, V9 (Cook) had gloves on and was checking the temperature of the food. After she would check the temperature she would take the pan of food to the steam table, come back and check the temperature of the next food item. This was done for the zucchini, gravy, pureed sweet potato, pureed turkey, regular sweet potato, mechanical soft sweet potato, mechanical soft turkey, and turkey crunch. V9 never changed her gloves. V9 touched the counters in the kitchen near the steam table with the same gloves on. V9 went over to the drawer under the stainless steel counter, opened the drawer, the scoops were in the drawer in all different directions. V9 rummaged through the drawer, withdrew 3 different scoops and handed them to V10 (Kitchen staff). The utensils drawer under the other side of the counter near the stove had scoops, ladles, and spatulas facing all different directions in the drawer.</p> <p>On 10/8/24 at 12:09 PM, V10 (Kitchen Staff) stated the scoops should be lined up in order of size in drawer. V10 confirmed the handles of the scoops and other utensils should be facing the same direction towards the opening of the drawer for infection control and to prevent cross contamination. V10 stated she is not the dietary manager. V1 (Administrator) was in the dietary office when V10 was questioned and stated V10, V8 (kitchen staff) and the dietician handle the kitchen operations right now.</p> <p>On 10/10/24 at 10:26 AM, V1 Administrator stated he did not have a policy for the storage of kitchen utensils and the prevention of cross contamination in the kitchen.</p> <p>The facility's Sanitation and Infection Control policy (1/30/24) showed to keep kitchen and storage areas neat and orderly. The policy did not state how utensils, scoops, ladles, etc. were to be stored to prevent cross contamination.</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>20042</p> <p>Based on observation, interview, and record review the facility failed to have policy and procedures in place for residents (R28, R186, &amp; R10) on enhanced barrier precautions. The facility failed to have a policy or plan for legionella. This failure has the potential to affect all 33 residents in the facility.</p> <p>The findings include:</p> <p>1. The Long-Term Care Facility Application for Medicare and Medicaid form dated 10/8/24 for the facility showed a census of 33 residents.</p> <p>On 10/10/24 at 10:26 AM, V1 (Administrator) stated the water treatment service reports that he has were from the water treatment company that comes in and checks the chemicals for their water. V1 stated he did not have a legionella policy or water treatment plan.</p> <p>On 10/10/24 11:33 AM, DON (Director of Nursing) stated the facility has a water treatment plan but it did not contain anything regarding legionella.</p> <p>The facility's Water Treatment System policy (1/4/24) showed the facility uses a reverse osmosis (RO) system to purify the water. The water treatment system purifies the water by removing contaminants through five processes as applicable: water softening, carbon absorption, reverse osmosis, resin based mixed-bed deionization, and post-submicron filtration. The policy explained what each of the five processes were. The policy did not have a water management plan.</p> <p>36186</p> <p>2. The facility face sheet for R10 shows diagnoses to include dysphagia and gastrostomy. The Physician Order Sheet (POS) dated October 2024 shows orders for a gastrostomy tube (G tube) for feedings, fluids and medication administration.</p> <p>The facility face sheet for R186 shows diagnoses to include retention of urine and neutropenia (low white blood cells). The POS dated October 2024 for R186 shows orders for his urinary catheter.</p> <p>The facility face sheet for R28 shows diagnoses to include urinary tract infections and obstructive and reflux uropathy (backflow of urine). The POS dated October 2024 shows orders for his urinary catheter.</p> <p>On 10/8/2024 to 10/10/24 no signs showing the residents were on enhanced barrier precautions were observed on the doors to the rooms for R10, R186 and R28. No personal protective equipment (PPE) was observed near the room and the staff were observed entering and exiting the rooms without wearing PPE.</p> <p>On 10/9/24 at 12:50 PM, V2 Director of Nursing said she first heard of enhanced barrier precautions the day before. V2 said the facility does not have a policy or a system set up for this. V2 said she believed the precautions included increased hand washing for residents who are neutropenic.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 10/9/24 at 1:41 PM, V4 Registered Nurse said enhanced barrier precautions are for residents with wounds, urinary catheters, feeding tubes and tracheostomies. V4 said the facility does not have a protocol for this. V4 said the staff should be wearing gloves when going into the room and signs should be on the doors.</p> <p>The facility did not have a policy for enhanced barrier precautions.</p> <p>The implementation of personal protective equipment uses in nursing homes updated 7/12/2022 from the Centers for Disease Control shows enhanced barrier precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.</p> |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Elmhurst Extended Care Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 East Lake Street<br>Elmhurst, IL 60126 |  |
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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Keep all essential equipment working safely.</p> <p>20042</p> <p>Based on observation, interview, and record review, the facility failed to maintain the kitchen freezer in a safe operating condition This failure affects all 33 residents in the facility.</p> <p>The findings include:</p> <p>The Long-Term Care Facility Application for Medicare and Medicaid form dated 10/8/24 for the facility showed a census of 33 residents.</p> <p>On 10/8/24 at 9:57 AM, during the initial tour of kitchen with V9 (cook) and V8 (kitchen staff) the walk in refrigerator door handle was broke; it was loose and didn't latch to keep the door tightly closed. The freezer door handle was broke and did not latch the door tightly closed to keep the freezer sealed. V9 and V8 were not sure when the handles broke; maybe over the weekend and maintenance doesn't work weekends. V9 and V8 stated maintenance was coming to fix it.</p> <p>On 10/8/24 at 12:09 PM, V10 stated she was not the dietary manager. V1 (Administrator) was in the kitchen and stated V10, V8 (kitchen staff), and the dietician handle the kitchen operations right now.</p> <p>On 10/8/24 at 12:17 PM, one of the panels of the plastic curtain at the entrance of the freezer inside the door was missing. The freezer had ice build up on the plastic curtain at the entrance of the walk in freezer. There was ice built up a on shelf to the left side of the freezer near the door. There was a large long ice icicle hanging from the ceiling of the back left side of the freezer. The case for the thermometer inside the freezer was present but not the thermometer itself. V10 (kitchen staff) stated that maybe the ice in the doorway of the freezer was preventing it from closing all of the way. V10 (kitchen staff) wasn't aware that the thermometer was gone. V9 (cook) stated she records the freezer temperature from the thermometer on the outside of the freezer; not the inside. V10 stated the freezer shuts off for a few minutes every once in awhile and then comes back on and she doesn't know why.</p> <p>On 10/9/24 at 9:11 AM, V7 (Maintenance) stated he has only worked at the facility 1 month and he is over the whole building. V7 stated he has not seen the maintenance books or logs for anything because he has only been here a month. V7 stated he doesn't know anything about the maintenance books and logs. V7 stated he would have to talk to his supervisor, V1 (Administrator). V7 stated he was told about the door handles to the freezer and refrigerator yesterday (10/8/24); he doesn't know what needs to be done; maybe order parts. V7 was not aware of any other problem with the freezer.</p> <p>On 10/9/24 at 9:15 AM, V1 (Administrator) stated, he doesn't know anything about the handles to the freezer or refrigerator. V1 stated maintenance is done when there is a problem and he is not aware of any problem to the freezer. V1 stated if there is condensation present for the freezer then there will be ice resent which makes sense if the door is not sealing all of the way. V1 stated he was not aware of any ice build up in freezer or missing freezer curtain panel.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145111 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>10/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Elmhurst Extended Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 East Lake Street<br>Elmhurst, IL 60126 |  |

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|---|--|
| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>The facility's Equipment and Maintenance policy (1/30/24) showed, the food service director will instruct dietary employees in the use and care of equipment. He/she will also order repairs and replacement of equipment and maintain records.</p> |