

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Waterford Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 7445 North Sheridan Road Chicago, IL 60626	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666</p> <p>Based on interview and record review, the facility failed to notify a resident's state guardian when the resident experienced a change in condition for one (R6) resident out of four residents reviewed for notification of changes in a total sample of six.</p> <p>Findings include:</p> <p>R6's face sheet documents R6 is a [AGE] year-old individual with diagnoses not limited to: dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, schizoaffective disorder, depressive type, and major depressive disorder.</p> <p>R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) of 09 out of 15, indicating R6 has moderately impaired cognition.</p> <p>R6's nurses note, dated 02/27/2025 at 5:44 PM, documents, resident (R6) was observed with a choking episode while eating dinner in the dining room. Resident was unable to swallow or cough out the obstructing food. The nurse on duty performed Heimlich maneuver and cleared her airway. Resident was assessed and noted to be saturating at 89-90% at room air. Supplemental oxygen administered at 2L/minute (liters per minute) via nasal cannula per order. Post oxygen administration, saturation at room air appreciated to 97%. Resident stable at this time and verbally responsive with no discomfort or pain verbalized. Vital signs were stable.</p> <p>No documentation within 24 hours that R6's guardian was notified regarding R6's choking incident and R6's change in oxygen saturation.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/10/2025 at 12:03 PM, via telephone, V10 (Registered Nurse) stated he remembers when R6 choked on the food. V10 stated, I was passing medication. The CNA (certified nursing assistant) called me that she (R6) was choking. I went there and noticed that she was struggling, and I performed the [NAME] maneuver. I was able to get the food to come back up to her mouth. She (R6) removed it with her hand when it came up to her mouth. It was like a bun/or something like bread. I checked her vitals and she was desaturating. I administered oxygen to her. When I was monitoring her, her oxygen level was within range. I called her provider. I was not able to reach her, so I notified the in-house Nurse Practitioner. The in-house Nurse Practitioner asked if she was OK, and she was ok. Staff monitored her the rest of the shift, and endorsed it to the next shift. No I didn't reach out, there was a time she kept saying that we shouldn't let people know her business. It wasn't this time, but a time before. V10 stated he was not aware R6 has a state guardian. V10 stated if he would have known, he would have notified the state guardian.</p> <p>On 04/10/2025 at 12:35 PM, V2 (Director of Nursing) states when a resident experiences a change in condition, the nursing staff or nurse on duty are supposed to call the doctor, then notify the resident's family or guardian. V2 stated, A resident unfortunately choking on food is a change in condition or an incident. It should be reported to the resident's family or guardian because they need to know, to let them know that something happened. Give the family or guardian an update and how the resident is doing now. V2 stated the nursing staff usually have around the same day/24 hours to notify the family or guardian of the update.</p> <p>Facility document, dated 05/2024, titled change in a resident's condition or status documents our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.</p> <p>R6's state guardianship document, dated 12/16/2021, documents nursing home protocol office of the public guardian. The nursing home must provide immediate notice to the office of the public guardian on a 24-hour basis regarding hospitalization , incident/accident, consent, and changes in our ward's physical or mental condition.</p>		