STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145679	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlton at the Lake, The	725 West Montrose Avenue Chicago, IL 60613

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to revise comprehensive care plans with preventive interventions to ensure resident safety for two of three residents (R3, R4) reviewed for injury of unknown origin. Findings include: 1. R3's (7/3/24) facility reported incident includes x-ray of right-hand: non-displaced fracture of the proximal third phalanx. (R3) is a poor historian due to diagnosis of dementia, so he is unable to give account of the fracture. When asked how he (R3) sustained the fracture, he pointed at the bedside table. On 7/5/24 while being interviewed, (V2/Director of Nursing) observed (R3) suddenly swing the affected hand but the side table was not in close proximity, otherwise the hand would have hit the table. It is concluded that the injury is a result of (R3) bumping the affected hand on his bedside table when he swung the right hand. R3's (7/9/24) care plan includes risk for injury related to poor safety awareness due to dementia. Resident noted with acute fracture of right 3rd finger as a result of bumping his bedside table when he swung his right hand. Interventions: administer pain medication as ordered. Call for follow-up appointment with plastic surgery, monitor the injured area for pain, swelling and other symptoms. [preventive interventions are excluded]. On 7/29/24 at 3:03pm, R3 was observed seated in the hallway with a bedside table placed above his lap. Surveyor inquired how R3 injured the right finger V6 (Licensed Practical Nurse) stated I don't know, I can't speculate. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145679	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlton at the Lake, The	725 West Montrose Avenue Chicago, IL 60613

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1:46pm, surveyor inquired about care plan requirements, V9 (Care Plan Coordinator) stated As soon as the team find out that there's an incident, we'll start to look at the care plans in the meeting. During that meeting, if there's interventions that need revised or added we do it at that time. Surveyor inquired if R3's (7/9/24) risk for injury care plan includes preventive interventions V9 responded Yes. We monitor the injury for pain, swelling, and other symptoms so before it gets worse, we already had monitored it [none of which will prevent injury]. Surveyor inquired how R3 injured his hand, V9 replied He (R3) bumped his hand on the bedside table. Surveyor inquired how the facility will prevent further injury to R3, V9 stated We have to assist the patient and make sure that he's not gonna bump anything. Surveyor inquired if assisting resident was on R3's risk for injury care plan, V9 responded No. Surveyor inquired why preventive measures such as assist the patient and/or moving the bedside table out of reach were not on R3's risk for injury care plan, V9 replied Honestly now that you told me, that's the first thing I'm thinking right now. It should be added. 2. R4's (6/23/24) facility reported incident states resident was observed with swollen area to his right leg. CT (Computed Tomography) scan result indicates tibial fibula fracture to the right leg. Residents' diagnosis includes hemiplegia/hemiparesis affecting right dominant side. Resident is non-verbal, unable to explain the cause of fracture. Staff affirmed that although R4's affected leg is paralyzed, he dangles the leg on the side of his bed, staff repositioned him with no incident of trauma or injury. [R4 moves his right leg by pushing it with the left leg]. It is concluded that the injury was sustained by (R4) bumping his right lower leg on the lower side rail of his bed in his attempt to push his right leg down the bed with his left leg. R4's (7/9/24) care plan states resident was noted with fracture of tibia fibula of unknown origin. Believed to be due to bumping his right lower leg on the bedside rail in his attempt to push his right leg down the bed with his left leg. Interventions: administer medication as ordered. Assess resident for any more injury, pain, and discomfort. Refer to medical doctor. Educate (R4's) son to call for staff help in any way when needed. [interventions to prevent R4 from harming himself are excluded]. On 7/29/24 at 2:52pm, R4 was lying in bed with padded (upper) siderails raised however nothing was in place to prevent lower extremity harm. The care plan policy (revised 6/6/24) states after the comprehensive assessment is completed, the facility will put in place person-centered plans outlining care for the resident within 7 days. These will be periodically reviewed and revised by a team of qualified person after each assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145679	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlton at the Lake, The	725 West Montrose Avenue Chicago, IL 60613

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that enteral feedings are administered as ordered, and failed to document enteral intake for two of three residents (R1, R4) reviewed for dehydration. Findings include: 1. On 7/2/24, IDPH (Illinois Department of Public Health) received allegations that the facility failed to monitor and adjust resident liquid intake thereby causing dehydration. The following concerns were identified: R1's diagnoses include anoxic brain damage, tracheostomy status, gastrostomy status, and dependence on respirator (ventilator) status. R1's POS (Physician Order Sheets) include (4/17/24) NPO (nothing by mouth) diet. Enteral feeding flush with 250ml water every 6 hours. (4/25/24) Enteral feeding Jevity 1.5 @ 60ml (milliliters)/hr (hour) start at 7am and turn off at 5am. R1's (12/21/23) care plan states resident is at risk for alteration in nutritional status related to NPO and tube feeding. Intervention: Give g (gastrostomy) tube feeding and water flush as ordered. Monitor for signs and symptoms of dehydration. R1's (5/21/24) BIMS (Brief Interview Mental Status) affirms resident is rarely/never understood. On 7/29/24 at 2:38pm, R1 was lying in bed and his eyes were open however he did not respond to verbal stimuli. R1's enteral feeding Jevity 1.5 was infusing at 60ml/hr and 250ml water flush was set up for every 6 hours. R1's enteral feeding was marked 7/29 and 11:30 however 1,000ml was observed in the Jevity bottle (the container was full) and the infused amount was noted to be over 5,000ml. On 7/29/24 at 2:45pm, surveyor inquired what time R1's enteral feeding was started V5 (Licensed Practical Nurse) stated It goes up at 7am, they start it. I just hung that at 11:00, I wrote the time on there. V5 subsequently inspected enteral feeding (as requested) and affirmed the Jevity bottle was hung at 11:30. Surveyor inquired if V5 started R1's Jevity at 11:30am and it was infusing at 60ml/hr why was there 1,000ml still remaining in the bottle, V5 responded I'm not sure. [195ml should have infused from 11:30am-2:45pm - 60ml/hr x 3.25 hrs]. Surveyor inquired about R1's enteral flush V5 replied At 12:00 he gets flushed 250ml's every 6 hours. This is a dual pump, so it flushes every 6 hours. Surveyor inquired how much Jevity R1 receives on the day shift (8 hours), V5 stated On my shift, he get 420. [60ml x 8 hours = 480ml]. Surveyor inquired why R1's infused amount states 5,266ml on the pump, V5 responded I didn't clear it out. Surveyor inquired if R1's intake is supposed to be monitored by staff, V5 replied Yeah. Surveyor inquired how R1's enteral intake is monitored if the pump was not cleared, V5 stated I guess based on what the machine's running on. Surveyor inquired when the enteral feeding pump should be cleared, V5 responded I guess at the beginning of every shift. [enteral feeding pumps should be cleared at the end of the shift]. Surveyor inquired why R1's g-tube pump wasn't cleared, V5 replied I didn't do it this morning; I can't speak for nobody else. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145679	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlton at the Lake, The	725 West Montrose Avenue Chicago, IL 60613

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R4's diagnoses include gastrostomy status, and dependence on respirator (ventilator) status. R4's POS includes (7/17/24) enteral feed order: Jevity 1.5 @ 50ml/hr start at 7am and turn off at 5am. Flush with 150ml water every 4 hours. R4's (12/14/24) care plan states resident requires enteral feedings as the primary source of nutrition due to dysphagia. R4's (7/25/24) BIMS affirms resident is rarely/never understood. On 7/29/24 at 2:52pm, R4 was lying in bed with his eyes open however did not respond to verbal stimuli. R4's enteral feeding Jevity 1.5cal was infusing at 50ml/hr. R4's (1,000ml) Jevity bottle was labeled 7/28 12p (over 24 hours ago). [if R4's Jevity was infusing at 50ml/hr the bottle should be empty within 20 hours]. Surveyor inquired when R4's enteral feeding was started V5 stated This was hanging this morning upon my arrival. On 8/1//24 at 1:16pm, surveyor inquired about R1 and R4's requested enteral intake documentation (which was not received), V3 (Assistant Director of Nursing) stated All of our patients that are on tube feeding, have orders that state when they should be turned on and turned off. Surveyor inquired if the facility monitors enteral input, V3 responded The Dietician makes the calculation of how much enteral feeding the resident is supposed to receive and the Nurses are responsible for following the order. Surveyor inquired if staff are documenting enteral intake, V3 replied No. The enteral tube feeding policy (revised 6/6/24) states enteral tube is an avenue of feeding and hydration nutritional support via gastrostomy tube. Nurse to check in the POS the order for enteral feeding interventions. Feeding type, rate, duration.