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	IL6002828	A. BUILDING: _____ B. WING _____	C 08/30/2024

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ELMHURST EXTENDED CARE CENTER	200 EAST LAKE STREET ELMHURST, IL 60126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2476702/IL177064 Investigation of Facility Reported Incident of August 5, 2024/IL176506	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to safely position a resident (R1) in bed during care and safely transfer the resident after a fall. This failure resulted in the resident falling out of bed and sustaining multiple rib fractures. The facility also failed to identify a resident's (R2) transfer status in the plan of care, safely transfer the resident, and apply a wheelchair positioning device for the resident with a known behavior of unsafely leaning to the side. This applies to 2 of 4 (R1 and R2) residents reviewed for safety.

The findings include:

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1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on 5/03/2024 with multiple diagnoses including chronic obstructive pulmonary disease, dementia, age-related osteoporosis with recurrent pathological fracture, osteoarthritis, acquired absence of the right upper limb, abnormalities of gait and mobility, and muscle weakness.

R1's MDS (Minimum Data Set) dated 8/05/2024 showed R1 was cognitively intact and dependent on facility staff for assistance with bed mobility and toileting. The EMR showed R1 was transferred to the hospital on 8/05/2024 and was not readmitted to the facility.

On 8/28/2024 at 3:00 PM, V11 (Certified Nurse Assistant/CNA) was interviewed regarding R1's fall incident on 8/05/2024. V11 said on 8/05/2024 at 4 AM she was going to render incontinence care to R1 in bed. V11 said she turned R1 on her right side away from her. V11 said she then turned away from R1 to gather incontinence supplies and left R1 unsupervised. V11 said R1 then fell out of bed on the floor. V11 continued to say she then immediately assisted R1 into a standing position and transferred her back to bed.

V12 (Agency Registered Nurse/RN) was not able to be reached for an interview during this survey. V12's untitled witness document dated 8/05/2024 said she was notified by V11 (CNA) that R1 fell out of bed while receiving incontinence care. The statement said R1 was in bed when she went to assess R1 after the fall. The statement continued to say R1 verbalized generalized pain and had sustained a skin tear to the left elbow, an abrasion to the left shin, and a bruise to the right knee.

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On 8/27/2024 at 12:35 PM, V2 (Director of Nursing/DON) said R1 was transferred to the hospital for further evaluation because she was complaining of acute generalized pain after her fall. V2 said the hospital informed the facility R1 had sustained multiple bilateral rib fractures. V2 said she expected the nursing staff to follow fall prevention precautions during bed mobility to ensure the safety of residents. V2 said V11 (CNA) should have not positioned R1 away from her nor should have left her unattended when she was rendering incontinence care. V2 continued to say V11 also should have not transferred R1 after she fell without having been assessed by the nurse.

R1's imaging hospital records dated 8/05/2024 showed R1 sustained "Right 6th-10th rib fracture deformities and left 9th-10th rib fracture deformities."

The facility's initial and final report titled Serious Injury Incident Report dated 8/05/2024 said R1 rolled out of bed when receiving incontinence care. The report said R1 was complaining of pain and was sent to the hospital and was treated for rib fractures.

R1's Fall Risk Evaluation dated 5/03/2024 showed R1 was at risk for falls.

On 8/28/2024 at 10:10 AM, V1 (Administrator) said the facility did not have policies regarding bed mobility and positioning. The facility's policy titled Fall Management Program dated 1/18/2024 showed "Definition: Fall management program is an interdisciplinary quality improvement design to assist in providing individualized, person center-care and improving fall care process and outcomes through quality improvement tools and

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education. Purpose: to prevent and/or decrease the number of falls and reduce injuries resulting from falls."

2. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on 6/26/2024 with multiple diagnoses including acute kidney failure, obstructive reflux uropathy, sepsis, hypotension, bilateral inguinal hernia, hepatomegaly, benign prostatic hyperplasia, constipation, pressure ulcers to right and left heel, congestive heart failure, and muscle disorder.

R2's MDS (Minimum Data Set) dated 6/28/2024 showed R2 was severely cognitively impaired and dependent on facility staff for assistance with transfers and mobility.

On 8/27/2024 at 11:27 AM, R2 was sitting in his reclining geriatric wheelchair. R2 did not have his wheelchair supportive arm device in place. V8 (CNA) and V10 (CNA) said they were going to transfer R2 to bed. V8 and V10 used a total mechanical lift machine to transfer R2. R2's legs were contracted in a fixed position and flexed towards his right side. R2 had a dressing to his right heel and bruising to his right inner arm and right lateral torso area extending to his anterior chest area. V9 (RN) came to R2's room to assess his bruises. V9 said R2 had a pressure ulcer to his right heel and his arm and torso bruising was noted last week. V8 and V9 said R2 did not have a recent fall or incident. They continued to say R2 had the tendency to lean on his right side when in his chair and was receiving blood thinners which they believed possibly caused the bruising.

On 8/27/2024 at 1:50 PM, R2 was in the dining room sitting in his reclining geriatric wheelchair.

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R2 did not have his wheelchair positioning supportive arm device in place.

On 8/28/2024 at 8:37 AM, R2 was in the dining room sitting in his reclining geriatric wheelchair. R2 did not have his wheelchair positioning supportive arm device in place.

On 8/28/2024 at 11:55 AM, V9 (RN) was interviewed regarding R2's transfer status. V9 said she was not sure what was R2's transfer status. V9 looked in R2's EMR and said she was not able to find R2's transfer status. V9 then looked at the facility's posted transfer status list and said it did not show R2's transfer status.

On 8/28/2024 at 4:30 PM, V8 (CNA) was interviewed regarding R2's transfer status. V8 said he was not sure what was R2's transfer status because he could not find it in R2's EMR nor on the facility's posted transfer status list. V8 said R2's transfer status varied, and he makes a "judgment call" daily when transferring R2. V8 said he sometimes transfers R2 quickly with one or two-person assistance and sometimes he uses the total mechanical lift by himself to transfer R2.

On 8/28/2024 at 9:50 AM, V16 (Director of Rehab) said R2 was discharged from therapy on 7/10/2024 with a recommendation to continue to be transferred with the use of a total mechanical lift because of his weakness, foot wound, and lower leg contractures.

On 8/29/2024 at 11:10 AM, V2 (DON) said R2 was observed leaning unsafely to his right side when in his chair. V2 said R2's bruise most likely occurred due to his poor trunk control and unsafe positioning. V2 said she expected the staff to ensure R2's wheelchair positioning arm device

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was in place to assist R2 be properly positioned and prevent him from sustaining any further injuries. V2 said R2's transfer status has always been total mechanical lift with a two-person assist. V2 said she reviewed R2's care plan and the facility's posted transfer status list and they did not indicate R2's transfer status. V2 said residents' care plans should identify their transfer status to ensure staff are aware on how to safely transfer residents. V2 said she expected staff to follow residents' transfer status and when using the total-mechanical lift a two-person assistance was required for safety.

R2's 7/10/24 Physical Therapy/PT Discharge Summary report said R2 was dependent on transfers and required the use of a mechanical lift. R2's document titled Follow Up Question Report dated 8/28/2024 (during the survey) showed R2's transfer documentation from 7/29/2024 through 8/28/2024. The document showed R2's transfer support provided varied from one-person physical assistance and two-person physical assistance. The document continued to show R2's transfer self-performance also varied from total dependence, extensive assistance, and limited assistance.

R2's care plan dated 8/28/2024 said R2 was at risk for bruising and injury because he favored his right side and leaned over on the right side of his wheelchair. The care plan showed an intervention to "Place right side arm rest bolster on the chair. Check and reposition resident while in (reclining geriatric) chair as needed for comfort." R2's care plan continued to show R2 required the use of the mechanical device (lift) for safe transfers which was initiated on 8/28/2024 (during the survey).

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S9999	Continued From page 8 On 8/28/2024 at 10:10 AM, V1 said the facility did not have policies regarding bed mobility and positioning. The facility's policy titled (mechanical) Lift dated 1/04/2024 showed "Purpose: A. To move a resident safely with as little physical effort as possible..." "A"	S9999		