STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING: _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S 000	Initial Comments Complaint 23810137/IL00167458	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)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	S9999		

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S9999	Continued From page 1 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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.	S9999		

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S9999	Continued From page 2	S9999		

These Requirements were not met evidenced by:

Based on interview and review of records, facility failed to follow their policy to ensure appropriate interventions are in place to prevent falls for 1 of 3 (R9) residents reviewed for accidents and hazards. This failure resulted in R9 sustaining a subdural hematoma and being hospitalized.

Findings include:

On 01/17/2023 at 11:35 AM, R10 stated that she was R9's roommate. R10 stated that the first night (R9) moved into this room (R9) had fallen. That was on 11/13/2023. R10 stated that (R9's) wheelchair was by the window, (R9) said that she was trying to get into her wheelchair and (R9) slipped. R10 stated that (R9) was not sent out to the hospital. R10 stated that (R9) fell a week later trying to get into (R9's) chair. R10 stated that (R9's) falling woke (R10) up from sleep. This happened between 11:00 PM and 12:00 AM. The next day (R9) fell again trying to get to (R9's) wheelchair. After the third time (R9) had fallen, (R9) did not come back to the facility. After all three times, R10 stated that she called the nurse by pressing the call light. R10 stated no one came in and checked in on (R9) all night before (R9) fell.

R10's MDS Section C (1/17/2024) documents in part: R10's BIMS score is 15 which means R10 is cognitively intact.

On 1/17/2023 at 12:45 PM, V20 (R9's POA) stated that R9 had fallen several times. V20 stated that she had her last fall there on 11/2023.

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S9999	Continued From page 3	S9999		

V20 stated that, R9's roommate witnessed three falls and she just called the staff and the staff members put her back in bed. V20 stated that the dates when they were notified when R9 had fallen was 6/10/2023, 9/23/2023, 11/17/2023, and 11/26/2023. V20 stated that the most recent fall was really bad and it put her in the hospital for a hemorrhage. That was on 11/26/2023.

On 01/17/2023 at 2:35 PM V14 (Fall Coordinator/Psychotropic Nurse) stated fall risk assessments are done upon Admission, resident falls, quarterly and annually. V14 stated that she is familiar with R9. In 2023 R9 fell on 5/11, 6/9, 6/10, 7/5, 9/23 and 11/16. V14 stated that on 11/16/2023 she sustained an acute subdural hematoma. On 11/16/2023, R9 stood up from the bed, she fell right away. V14 stated that resident fell at 10:30 PM.

R9's Progress note on 11/13/2023 documents in part: During the start of the shift round, resident noted to have left eye redness with swelling in the left peri-orbital area. No discharges noted, no indication of non-verbal pain. The resident is unable to provide information regarding the aforementioned redness and swelling d/t cognitive impairment. In-house NP notified with order to send to local hospital for CT-scan of the head. DON made aware and examined the resident. Contacted the resident's POA and informed the resident's current condition and order to send to outside hospital.

R9's progress note by nurse practitioner on 11/20/2023 documents in part: Patient is a 101 year old female seen and examined today to follow up in regards to recent fall. patient had a fall on 11/16 and was sent to the hospital for evaluation, patient was admitted for subdural

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S9999	Continued From page 4 hematoma. Reviewed R9's care plan. No updated interventions after fall on 11/13/2023. Multiple interventions are repeated for multiple falls. R9's POS (11/13/2023) documents in part: Send to hospital for CT scan of the head related to left eye swelling and redness. Facility's Fall Prevention Program policy (12/5/2021) documents in part: All fall incidents shall be monitored, analyzed, root causes identified by the DON or designee. An incident report will be completed by the nurse each time a resident falls. The falls coordinator will review the incident report and conduct his/her own fall investigation to determine the reasonable cause of fall. (A)	S9999		