Illinois Department of Public Health

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 05/08/2023

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

(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 Investigation: 2382412/IL157885 2382815/IL158367	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

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:

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.

These requirements were not met as evidenced by:

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Based upon observation, interview and record review the facility failed to timely address change in condition for two of eight residents (R5, R7) in the sample, failed to document (R5) physical assessment, pain rating and/or vital signs and failed to administer (R5) pain medication. These failures resulted in R5 sustaining 3+ pitting edema and pain rated 10/10. The facility also failed to monitor R7's indwelling urinary catheter. This failure resulted in R7 sustaining altered mental status, low blood pressure, fever and UTI (Urinary Tract Infection) secondary to sepsis.

Findings include:

1. On 4/4/23, IDPH (Illinois Department of Public Health) received allegations that facility staff ignore resident symptoms and fail to provide treatment.

R5's diagnoses include SIADH (Syndrome of Inappropriate Secretion of Antidiuretic Hormone Secretion) and hyponatremia.

R5's POS (Physician Order Sheets) include (1/24/23) Sodium Chloride 2 grams three times daily for electrolyte and (1/30/23) Tolvaptan (treats low sodium blood levels) 15 milligrams daily for SIADH.

R5's (4/6/23) BIMS (Brief Interview Mental Status) determined a score of 11 (moderate impairment).

On 5/3/23 at 1:30pm, R5 appeared to be distressed, teary eyed and calling out for assistance. Surveyor inquired if something was wrong R5 stated "I need the Nurse, I press the button and nobody coming. My arms, they stay big, they're so big and I have pain (10/10). I got

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to go to the hospital and the manager or nurse not coming. They (staff) never coming, they never come because I have a problem." R5 appeared emaciated however both upper extremities were shiny with taut skin and notably edematous.

On 5/3/23 at 1:36pm, surveyor inquired about R5. V24 (Licensed Practical Nurse) stated, "She (V24) was notified of pain on the finger, so I offered her (R5) pain medicine, like Tylenol." Surveyor inquired if R5 received Tylenol today. V24 responded, "I haven't given it to her right now." Surveyor inquired about R5's upper extremities. V24 responded, "The CNA (Certified Nursing Assistant) told me she was complaining of pain, and I checked the hand and the vitals (R5's alleged assessment and/or vital signs were not documented). When I touched her, I asked if she had any pain she said yes, so I need to give Tylenol." Surveyor inquired why R5's bilateral upper extremities were notably edematous. V24 replied, "She's on sodium, so I might be thinking from that sodium she might get swollen fingers." (R5's 5/3/23 Medication Administration Record affirms R5 received Sodium Chloride at 9am and 1pm). Surveyor requested the stage of R5's edema. V24 pressed the top of R5's left hand which was pitting and stated, "I think it's a 3." Surveyor inquired if the physician was notified of R5's changes in condition (pain/edema). V24 responded, "I haven't called yet."

On 5/3/23 at 1:53pm, V3 (Assistant Director of Nursing) entered R5's room (as requested). Surveyor inquired about R5's change in condition. V3 stated, "I know she (R5) was seen by the NP (Nurse Practitioner) today. I'm going to call the NP to let her know about the bilateral edema." R5 emphatically affirmed that the NP did not see

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her today. V17 (Social Service) subsequently translated for R5 and stated, "She (R5) says everybody that comes to the room goes to her roommate."

On 5/3/23 at approximately 2:05pm, V3 stated, "I misspoke, the NP did not see her (R5) today, she saw the roommate."

R5's electronic medical records affirm vital signs and pain level were last documented on 5/2/23 at 9:49am (the day prior).

R5's (May 2023) Medication Administration Record affirms Tylenol was not documented.

R5's (5/3/23) hospital history & physical states patient cachectic and edematous on exam. Suspect malnutrition as etiology of edema.

2. On 5/3/23 at 12:35pm, V23 (Family) stated, on 4/1/23 he contacted V12 (Agency Licensed Practical Nurse) via phone to report that R7 was not feeling well. He (V23) requested she (V12) check on (R7) however (V12) stated she was busy and would try to check on (R7) later. V23 immediately went to the facility and found R7 warm to touch and hallucinating. R7 also has a history of UTI (Urinary Tract Infection) and his urine was dark brown in the catheter bag therefore V23 requested an ambulance. V23 stated, "R7's blood pressure was 66/30 when EMS (Emergency Medical Service) arrived."

On 5/8/23 at 12:11pm, surveyor inquired about R7's (4/1/23) change in condition. V12 stated, "The son came in (4/1/23) and asked me to come check his father, said he (R7) wasn't feeling well so I took his vitals. He (R7) felt warm and had a temperature. His son wanted him (R7) sent out

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and I sent him (R7) to the hospital." Surveyor inquired if R7's son (V23) called V12 (on the phone) prior to arrival. V12 responded, "He (V23) did, he just said that his father sounded confused."

R7's (4/1/23) progress notes state (11:45am) resident was noted with a urine output:300cc (cubic centimeters) with amber colored urine. Son came and requested that father be transferred to the hospital for evaluation. Vital Signs:121/64, 84, 20, 95% at room air, 103.5 axillary (therefore above 104F oral). Left message with doctors answering service at 12:38pm (53 minutes later). Spoke to nurse practitioner at 12:40pm, ordered for resident to be transferred to Hospital for evaluation. Resident is admitted to hospital due to sepsis and hyponatremia

R7's (4/1/23) hospital records include chief complaint fever and altered mental status. Sent to emergency room with hypotension and temperature 103.5 at skilled nursing facility. Blood pressure as low as 61/33 secondary to sepsis, urinalysis dirty. Physician reports that he (R7) came with (indwelling urinary catheter) which was dirty and changed in the emergency department. White blood cells 12.8 (high). Urinalysis positive for UTI.

On 05/08/23 at 1:33pm, surveyor inquired about staff requirements for resident change in condition V27 (Medical Director) stated, "If there's a change in the patient's status after the nurse assesses the patient the primary physician should be notified." Surveyor inquired about a timeframe for reporting resident change in condition. V23 responded, "I'm not sure that I can put a timeline on anything. If somebody becomes short of

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S9999	Continued From page 6 breath or has chest pain, then I think there is urgency and they should call the physician immediately." Surveyor inquired about potential harm to a resident with a temperature 103.5 (axillary) not addressed. V27 responded, "I think in that situation and the temp is 103.5 then I would expect a call right after she took the temperature." Surveyor inquired about potential harm to a resident prescribed Sodium Chloride daily and Tolvaptan with (3+ pitting) upper extremity edema V27 replied "Localized swelling in the arms would not happen from those medications, it would be a generalized edema not only upper extremities so there could be other reasons. It could be thrombosis, that would be something we would need to rule out or it could be nutritional. Surveyor relayed concerns with R5 & R7's delayed care at the facility. V27 responded, "The nurses need to do a thorough and accurate assessment of the patient and address those issues." The notification for change in condition policy (revised 7/28/22) states the facility must immediately consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status (ie: deterioration in health). Per federal definition 483.10(g)(14), a need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (eg: an adverse drug reaction) or commence a new form of treatment to deal with a problem. (A) Statement of Licensure Violations (2 of 2) 300.3240d)	S9999		

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Section 300.3240 Abuse and Neglect

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

This requirement was not met as evidenced by the following:

Based upon record review and interview the facility failed to report abuse to IDPH (Illinois Department of Public Health) within regulatory requirements for one of three residents (R6) reviewed for abuse. This failure has the potential to affect 177 residents.

Findings include:

The 5/1/23 census includes 177 residents.

R6's initial abuse report includes date when staff became aware of the incident (3/21/23). Resident's aunt left a message on the administrator's voicemail, stated on Saturday while resident was being provided care that the staff member inserted their finger into the resident's rectum.

R6's final abuse report was submitted to IDPH on 3/29/23 (8 days after the allegation was received).

On 5/8/23 at 2:58pm, surveyor inquired about the regulatory requirement for abuse V13 (Assistant Administrator) stated "The initial is due within 2 hours and then 5 days for the final. We email it to IDPH." Surveyor inquired why R6's follow-up investigation was submitted to IDPH on 3/29/23 V13 replied "I guess we sent it in late."

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S9999	Continued From page 8 The (10/24/22) abuse and neglect policy states a final investigation will be submitted to IDPH within 5 working days (C)	S9999		