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 11/02/2023

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2388128\IL164957 Facility Reported Incident of 10/25/23/IL166083	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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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	S9999		

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on interview and record review the facility failed to perform a two person assist for repositioning in bed for a dependent resident (R5), who was assessed as a two person assist for bed mobility. This failure resulted in R5 sustaining an acute, mildly displaced proximal left humeral fracture.

Findings include:

R5 has a diagnosis which includes but not limited to hypoxic ischemic encephalopathy, localized swelling mass, and lump left upper limb, osteomyelitis, colostomy, chronic respiratory failure with hypoxia, tracheostomy, dependence on respirator, flaccid neuropathic bladder, presence of urogenital implants, gastrostomy, dysphagia, type 2 diabetes.

R5's Brief Interview for Mental Status (BIMS) dated 10/14/23 documents a BIMS of 00 which indicates that R5 is not cognitively intact.

On 10/30/23 at 11:35 am, R5 was observed in bed awake, alert, and was able to nod R5's head and blink R5's eyes to yes and no questions however, R5 was not able to answer open ended questions. R5 was also observed with a sling to R5's left arm area.

On 10/30/23 at 12:04 pm, V8 (Registered Nurse, RN) stated, on 09/27/23 V8 was the oncoming

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nurse for the 7:00 am to 3:00 pm shift on the third-floor unit. V8 stated, V8 and V33 (RN) from the 11:00 pm to 7:00 am shift, performed walking rounds on the third-floor unit, on 09/27/23. V8 stated, V8 and V33 observed R5's left arm stretched out, swollen with greenish bluish discoloration. V8 explained, R5's arms are usually observed in a contracted formation. V8 stated, V8 and V33 then called V2 (Director of Nursing, DON) to assess R5's left arm. V8 stated, V33 stated that V33 did not observe R5's arm swollen when V33 gave R5, R5's morning medication. V8 then stated, V2 came to R5's room and assessed R5's left arm swelling and discolored and V2 then called V38 (R5's nurse practitioner) to inform V38 of R5's swollen left arm. V8 stated, V38 came into the facility around 9:00 am on 09/27/23 and assessed R5's left arm and ordered a STAT (urgent) X-ray and a Doppler for R5's left arm to be performed. V8 stated, the results of R5's X-ray did not arrive during V8's shift. V8 stated, when V8 returned to work in two days, R5 had a sling to R5's left arm and V8 was informed that R5 had a fractured left arm.

On 10/30/23 at 12:16 pm, V9 (Certified Nursing Assistant, CNA) stated, on 09/27/23 when V9 arrived on the third-floor unit V8 and V33 were in R5's room assessing R5's left arm before V9 was able to provide any care to R5. V9 stated, V9 did not work on 09/26/23.

On 10/31/23 at 1:20 pm, V33 (Registered Nurse, RN) stated, on 09/27/23 during walking rounds with V8, V8 observed R5's left hand swollen. V33 stated, V8 called V2 to assess R5's hand and V33 then went home. V33 also stated V33 last saw R5 around 6:00 am when V33 gave R5, R5's medications through the gastrostomy (GT) tube, that R5's left hand was underneath R5's covers

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and that R5's left hand was not visible to V33. V33 explained, V33 only observed R5 to see if R5 was breathing okay during the night and V33 did not provide R5 with any care that allowed V33 to see R5's left hand. V33 also explained, V34 (Certified Nursing Assistant, CNA) provided patient care and repositioning to R5 and did not report any abnormalities to V33 regarding R5 during the shift. When V33 was asked if V33 helped V34 with repositioning or providing care to R5 during the night shift on 09/27/23, V33 stated, "The CNA (V34) provided care by herself (V34). If she (V34) needs help. She (V34) would go to get the other CNA (V32)."

On 10/31/23 at 1:36 pm, V32 (Certified Nursing Assistant, CNA) stated, V32 is not familiar with R5 and that V32 has never provided care to R5. V32 explained, V34 did not ask V32 for any assistance with providing R5 care or repositioning on 09/27/23.

On 10/31/23 at 2:42 pm, V34 (Certified Nursing Assistant, CNA) stated, V34 was R5's CNA on 09/27/23. V34 stated, on 09/27/23 V33 assisted V34 every two hours with providing care and repositioning R5. V34 stated, V34 and V33 used a sheet to turn and reposition R5. V34 stated, V34 last provide care to R5 with V33 around 5:00 am on 09/27/23 and V34 did not observe R5's arm swollen or discolored.

On 11/01/23 at 10:23 am, V38 (R5's Nurse Practitioner) stated, V38 recalls being called regarding R5's having a left arm injury a few weeks ago. V38 stated, V2 called V38 and stated, R5 had swelling and purplish discoloration to R5's left hand. V38 stated, V38 assessed R5's left arm and ordered an x-ray of R5's left arm that showed that R5 had a left arm fracture. V38 then stated,

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V38 gave orders for R5 to go to the local hospital. V38 explained, R5 is a resident that requires total care from staff and R5 cannot reposition himself (R5). V38 stated in V38's professional opinion to safely reposition R5, R5 should have two staff members for repositioning. V38 explained, if one staff member provides repositioning for R5, the staff can potentially injury the resident, themselves (the staff member) and that R5 may not be effectively repositioned. V38 stated, during repositioning of R5 one staff member should be on each side of the R5's bed to assist with effectively repositioning R5. When V38 was asked regarding how R5 could have sustained R5's left arm fracture if R5 is a resident that cannot move or repositioning himself (R5), V38 stated that R5 cannot move himself (R5) and R5's injury could have potentially happened during repositioning or during care that was being provided to R5.

On 11/01/23 at 10:41 am, V39 (Restorative Nurse, Licensed Practical Nurse, LPN) stated, R5 is a resident that has been assessed as totally dependent on staff for care and requires two persons assist at all times for transfers and bed mobility. V9 was asked regarding if a resident who is assessed for two persons assist for bed mobility should ever have one staff member for repositioning. V39 stated, "No. That is not safe for the resident." V39 explained if a resident is assessed for two persons assist for bed mobility and repositioning and one staff member repositions the resident alone, the resident and the staff can get hurt. V39 was asked regarding how R5's left arm fracture occurred if R5 cannot move or reposition himself (R5). V39 stated, "Even with two persons assist, R5's contractures and limitations, I (V39) would have to say R5's arm fracture happened when staff was moving

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R5."

On 11/01/23 at 12:04 pm, V2 (Director of Nursing, DON) stated, R5 depends on staff for all of R5's care. V2 stated, R5 is alert and eyes are open but cannot answer open ended questions. V2 stated, about one month ago during the morning shift V2 was notified by V8 (RN) that R5's left hand was swollen. V2 stated, V2 assessed R5's left arm and observed swelling to R5's left arm and called V38 (R5's Nurse Practitioner). V2 stated, V38 ordered and x-ray to be performed on R5's left arm and the results of R5's left arm x-ray was a fracture. V2 stated, V38 then gave orders for R5 to be sent to the local hospital. V2 explained, R5 cannot move any of R5's extremities and that R5 has been assessed as a dependent resident that requires two-persons assist from staff. V2 also stated during R5's two persons assist for repositioning one staff member should stand on each side of R5's bed for support and a sheet should be used during turning. V2 also explained, the expectation of the facility is for staff to follow the assessment of the resident at all times and R5 has been assessed as two persons assist and should never have one staff providing care such as repositioning. V2 explained, if one staff member is providing care to R5 for repositioning there is a possibility of R5's arm to get stuck and injured when turning R5. V2 was asked regarding how R5's left arm fracture occurred. V2 stated, V2 concluded in V2's final report investigation to the local state agency regarding R5's left arm fracture that R5's injury happened during repositioning."

R5's Minimum Data Set (MDS) dated 09/26/23 documents in part that R5 is dependent for staff care, two persons assist for bed mobility. Helper does all of the effort. Resident does none of the

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effort to complete the activity, the assistance of 2 or more helpers is required for the resident to complete the activity.

R5's progress note authored by V8 (Registered Nurse, RN) documents in part that: "During morning round, the writer noticed that skin discoloration and swelling on the residents left arm. V2 (Director of Nursing, DON) and V38 (R5's Nurse Practitioner, NP) was notified and STAT (immediate) Doppler test and X-ray of left shoulder, humerus, elbow radius and ulna after assessing the resident. The order was carried out."

R5's radiology results report dated 09/28/23 at 05:08 am, documents in part that: Findings: Mildly comminuted, displaced fracture of the surgical neck of the humerus. Adjacent soft tissue swelling.

The facility's document dated 10/31/20 and titled "ADL (Activity of Daily Living) Care" documents in part: " ADL care is provided for each resident in the facility in accordance to the residents comprehensive assessment and care plan in order to identify, evaluate, and intervene to maintain, improve, or prevent an avoidable decline in ADL's ... i. Other ADL support and assistance in accordance to the restorative nursing assessment and/or comprehensive resident assessment" reviewed.

R5's hospital record dated 09/28/23 documents in part: R5 was seen in the emergency department for an arm fracture. R5 was placed in a sling and recommended to be non-weight bearing per orthopedic surgeons.

R5's Facility Reported Incident initial report to

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S9999	Continued From page 8 state agency dated 09/28/23 at 8:27 am, documents, in part: "R5 noted with left arm edematous. V38 made aware with orders for duplex scan of the left upper extremity and x-ray of the left shoulder, left humerus, left elbow, and left forearm. X-ray." R5's Facility Reported Incident final report to state agency dated 10/03/23 at 4:38 pm, documents, in part: "From the staff interviews conducted and the review of R5's medical records, it is concluded that no abuse had occurred, there is high possibility that the acutely mildly displaced fracture of the humerus could be caused by unintentionally and unknowingly due to positioning the resident on the affected arm while providing care." (B)	S9999		