STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ______ B. WING ______	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S 000	Initial Comments Annual Licensure and Recertification Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to implement interventions to reduce the risk of accidents for 1 resident (R53) of 6 residents reviewed for falls. This failure resulted in R53 sustaining multiple falls and sustained a hip fracture. Findings include: On 12/06/22 at 12:35 PM, observed R53 pushing wheeled bed table from R53's room toward the doorway of the room wearing dark blue regular socks. There were no non-skid strips on the socks. On 12/06/22 at 12:40 PM, V18 (Restorative Aide) stated that R53 likes to push his over the bed table out of his room and down the hall. V18 stated R53 is sometimes difficult to redirect and is at high risk for falling. On 12/07/22 at 11:24 AM, V14 (MDS/Restorative Coordinator) stated that R53 has dementia and is	S9999		

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S9999	Continued From page 2 very confused. V14 stated that R53 has a short attention span, is difficult to redirect and won't stay involved in activities. V14 stated that R53 has been having multiple falls back-to-back. V14 stated that any resident who has a fall is accessed for injury by the nurse on duty, and that the nurse on duty then notifies the doctor and family and completes a post fall evaluation form. V14 stated every fall is discussed with a team made of up the DON, Therapy Director and herself and care plans would then be modified. V14 stated all care plan interventions should be specific and evaluated for effectiveness. During interview on 12/08/22 at 09:42 PM, V18 stated that R53 is allowed to walk unassisted and that R53 is constantly getting up and down throughout the day unless he (R53) is sleeping. V18 stated that R53 does not want to sit down for very long and wants to be constantly walking around. V18 estimated R53 will sit down for a total of 15 minutes and then get up to walk around, and then sit back down for 15 minutes and then get back up again to walk around in his (R53)'s room and on the unit. V18 stated R53 has had multiple falls and that the staff tries to keep a closer eye on him (R53) but that it is hard because he (R53) is so active. V18 stated that she (V18) has known R53 for over one year and that R53's mental status has been decreasing. V18 stated that R53 is more forgetful, has greater difficulty understanding/following direction, and does not always respond to verbal cues. V18 stated R53 now requires extensive assistance with ADL care. V18 stated that interventions in place to help prevent R53 from falling include R53 wearing non-skid socks. On 12/08/22 at 9:54 AM V22 (Director of Rehabilitation) stated that R53 has a history of	S9999		

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S9999	Continued From page 3 falls and that R53 was referred to physical and occupational therapy due to falls. Occupational therapy was discontinued 10/21/22, and physical therapy is still working with R53 on functional ambulation, balance, and transfers. On 12/8/22 at 12:20 PM, V3 (Acting Director of Nursing/Nurse Consultant) stated that anytime a resident has a fall an investigation needs to be done to look at reasons for the fall. V3 stated that "The Morse Fall Scale Evaluation" is completed by nursing after every fall and that once the root cause for the fall is determine then there should be intervention(s) updated on the resident's care plan. The interventions should be re-evaluated and adjusted as needed or as appropriate for that resident. V3 stated that some of the root causes of falls may be cognition based and that the overall goal of the facility is to prevent future falls. On 12/8/22 at 12:33 PM, V28 (Occupational Therapist) stated R53's falls are related to cognition, mood and behavior and that R53 "won't stay in one place for long." V28 states R53's physician ordered for R53 to wear a helmet however R53 refused to wear it. On 12/8/22 at 2:19 PM, V14 (MDS/Restorative Coordinator) stated that R53 required a combination of supervision and limited assistance for bed mobility, transfer, walking in room and locomotion on the unit based on the MDS dated 07/06/22 which is before R53 started having multiple falls. V14 stated that based on the 09/09/22 Significant Change MDS R53's functional status changed from supervision and limited assistance to extensive assistance for bed mobility, transfers, walking in room, and locomotion on unit. V14 stated that the change in function was caused by the hip fracture injury	S9999		

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S9999	Continued From page 4 sustained from the fall. V14 stated that a "Morse Fall Scale Evaluation" is to be completed by the nurse on duty after every fall and that it is the Director of Nursing responsibility to update the fall care plan within 24-72 hours after every fall. V14 stated that R53's fall on 8/22/22 was not care planned, only the intervention of putting R53 on the "Falling Leaf Program" was added. V14 stated that the "Falling Leaf Program" notifies the staff that that particular resident is at high risk for falls by using a visual picture of a leaf outside R53's door but that there are no specific interventions associated with this program. V14 stated there were no changes made to R53's fall care plans interventions after the following falls had occurred: 10/6/22, 10/20/22, 10/31/22, 11/4/22. On 12/8/22 at 3:10 PM, V27 (Nurse Practitioner) stated that R52 sustained a hip fracture from a fall and dislocated his finger due to falls. V27 stated that the injuries were directly related to fall and that the injuries caused a change in R53's condition. V27 stated that R53 is very confused and difficult to redirect. V27 stated that R53 does not have a walking problem and that the falls are attributed to R53's cognition related to dementia. V27 stated R53 is not aware of his (R53) surroundings, does not always respond to redirection and can yell and become physical with staff. V27 stated that R53 needs one on one supervision to prevent continued falls however the facility is not able to provide one on one supervision. R53 was admitted to the facility on 09/28/2020 with diagnosis included but not limited to Unspecified Dementia, Unspecified Protein Calorie Malnutrition, Age Related Cataract Bilateral, Hallucinations. R53's care plan dated	S9999		

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S9999	Continued From page 5 11/2/20 documents R53 is at high risk for falls related to cognitive impairments secondary to dementia, generalized weakness, poor safety awareness and impulsive behavior. R53's MDS (Minimum Data Set) from 07/06/22 BIMS (Brief Interview for Mental Status) score is 06 indicating severe cognitive impairment. R53's MDS from 07/06/22 functional status documents in part R53 required supervision (encouragement, oversight or cueing) for walking in room and locomotion on unit and limited assistance (resident highly involved in activity, staff to provide non-weight-bearing assistance) for bed mobility, transfer and walk in corridor. Per record review, on 08/22/22 at 03:48 AM, R53 had an unwitnessed fall in his (R53)'s room while trying to go to the bathroom with no acute signs of injury. No imaging ordered. R53's fall risk care plan dated 11/02/20 documents in part as an intervention on 08/22/22 as "Falling Leaf." Surveyor reviewed records and no other interventions were added at that time. No "Morse Fall Scale Evaluation" or Post Fall Observation Assessment on 08/22/22 or 08/23/22. Per record review on 08/30/22 at 7:20 AM, R53 had an unwitnessed fall in the hallway. "Morse Scale Evaluation" (post fall) completed on 08/30/22 documents in part R53's score as 65 indicating high risk. Radiology scans from 08/31/22 documented in part R53 complaining of pain and limping, and findings consistent with intertrochanteric fracture. R53 was sent to the Emergency Room (ER) for evaluation on 08/31/22. R53's hospital discharge records document in part diagnosis Closed Avulsion Fracture of Greater Trochanter of Femur, Left. R53 was not a surgical candidate and was transferred back to the facility on 08/31/22. R53's	S9999		

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S9999	Continued From page 6	S9999		

care plan was updated on 08/31/22 to include in part, provide non-skid footwear, room close to nursing station for observation, and Physical and Occupational Therapy evaluation.

On 09/01/22 R53 sustained another fall. Surveyor reviewed records and there was no documentation in progress notes about this fall on this date. At 21:52 on 09/01/22, a "Morse Fall Scale Evaluation" was completed by nursing post fall. Nurse Practitioner progress note on 09/05/22 documents in part, upon return to the facility from the hospital (8/31/22) the following day R53 had another fall. R53 had new care plan created on 09/01/22 due to significant change status related to left hip fracture. There were no changes made to the fall risk care plan at this time.
R53's Significant Change MDS (Minimum Data Set) from 09/09/22 BIMS (Brief Interview for Mental Status) score is 05 indicating severe cognitive impairment. R53's MDS from 09/09/22 section G for functional status documents in part R53 required extensive assistance (staff providing weight-bearing support) walking in room, locomotion on unit, bed mobility, transfer, and walk in corridor.

Per nursing progress notes on 09/27/22 at 18:10, R53 had a witnessed fall wherein R53 lost his balance, leaned against bathroom door, and slid down to the floor. Surveyor reviewed fall care plan and the only intervention added was "redirection by staff as needed" on 09/27/22. Note R53 already had an intervention in place which stated, "redirect resident when noted to be agitated" from 01/18/21.

Per nursing progress notes on 09/29/22 at 08:12 AM, R53 had a witnessed fall in R53's room wherein he(R53) landed on his (R53)'s buttocks.

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S9999	Continued From page 7 Per nursing progress notes on 09/29/22 at 12:12, documents in part, R53 had another fall in the hallway wherein he (R53) lost his balance and fell to the floor. R53's left hand 4th finger noted to be abnormally aligned and moved left hand with some difficulty. R53 was transferred to the ER and returned with diagnosis Closed Dislocation of Finger of Left Hand, 4th finger with brace on 09/29/22 at 21:46. Surveyor reviewed fall care plan with new intervention added (10/4/22) for titration of Namenda. Per nursing progress notes on 10/06/22 at 17:30, documents in part R53 had a fall. "Morse Fall Scale Evaluation" (post fall) completed on 10/06/22. Surveyor reviewed fall care plan with no new interventions added. Per nursing process notes on 10/16/22 documents in part, R53 had a recent fall. "Morse Fall Scale Evaluation" (post fall) completed 10/17/22. Surveyor reviewed fall intervention care plan with new intervention added on 10/17/22 to remove tray immediately after all meals. Per nursing progress notes on 10/20/22 at 8:32, documents in part, R53 observed laying on the floor by the food of bed. Surveyor reviewed fall prevention care plan with no new interventions added. Per nursing process notes on 10/31/22 at 14:18, documents in part, R53 had a recent fall. "Morse Fall Scale Evaluation" (post fall) completed on 10/31/22. Surveyor reviewed fall prevention care plan with no new interventions added. Per nursing progress notes on 11/12/22 at 7:00, documents in part, R53 had a recent fall. "Morse Fall Scale Evaluation" (post fall) completed on	S9999		

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S9999	Continued From page 8 11/12/22. Surveyor reviewed fall prevention care plan with new intervention for helmet use added on 11/13/22. Per nursing progress notes on 11/14/22 at 3:10, documents in part, nursing heard a loud boom and observed resident laying on the floor next to the bed and body assessment completed with small laceration to the inside of the left ear and laceration to the left elbow and elbow was swollen. Surveyor reviewed fall prevention care plan with no new interventions added. Facility policy titled, "Morse Fall Scale Evaluation and Falling Leaf Program" dated 10/18/22 documents in part that the facility targets selected residents who are at risk for falls, fall risk is based on the fall risk factors, the fall scale is completed after a fall. Residents placed on the Falling Leaf Program may have a "falling leaf" placed outside their door, above their bed to visually identify the resident needing special precautions to avoid falls. Facility policy titled, "Fall Prevention Program" dated 11/21/17 documents in part, the purpose is to assure the safety of all residents in the facility, implementation of appropriate interventions to provide necessary supervision, care plan to address each fall, interventions are changed with each fall, as appropriate, and a Fall Risk Assessment will be performed after any fall incident. (A)	S9999		