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
	IL6006191	A. BUILDING: ______ B. WING ______	07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NILES	8333 WEST GOLF ROAD NILES, IL 60714

(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 Annual Licensure and Certification Survey Complaint investigations: 2394711/IL160690 Facility Reported Incident of 6/14/2023/IL161873	S 000		
S9999	Final Observations Statement of Licensure Findings: 1 of 2 Violations 300.610a) 300.1210b) 300.1210d)3 300.1210d)5 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation interview and record review the facility failed to ensure that one residents (R313) wound was assessed properly and worsening wound was identified, and doctor was notified for one resident R313 of 3 residents reviewed for wounds in a sample of 33.	S9999		

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Findings include:

On 7/20/23 at 1:16 PM with V11 (Wound Care Coordinator) reviewing pictures and documentation of R313 sacral wound. All of the sacral wound assessment each week documents the wound to be 5x7/0 CM, area to be 35 centimeters, and the tissue to be bright pink or red=100%.

4/19/23 picture V11 states that there is some slough on the sacral wound and that V41 (Wound care nurse) assessment is incorrect but the treatment ordered is correct. Wound size documented 5x7x0 and 100% pink tissue.

4/26/2023 picture V11 states slough is more of non-adherent slough. There is a new/wider wound on the left buttock next to/attached to original sacral wound. V11 states there is more dead tissue and the measurement that V41 put is incorrect and yes these findings would signify a change in condition.

5/1/2023 picture measurement not correct some necrotic tissue.

5/8/2023 V11 states measurement incorrect and some necrotic tissue. V11 states she would say that this wound is unstageable with 90-95% slough and 5% pink viable tissue again what V41 documented is incorrect.

5/16/2023 picture V11 states the wound is unstageable and 95% slough.

On 7/20/23 at 2:52 PM V2 (DON) states V2 states she expect if there is a change in condition or worsening wound that the staff will notify family and doctor and measure wound and chart what

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they see. Documentation should be in the resident's electronic medical record in the progress notes or wound rounds. V2 states she assumes within 24 hours of a change of condition the doctor and family should be notified.

On 7/21/2023 at 1:45 PM V28 (Nurse Practitioner) states they defer to wound care doctor to assess as soon as possible during next wound round. The facility should notify nurse practitioner and wound care doctor if worsening. V28 states a stage 4 wound should be consulted right away . V28 states Nothing should be delayed when it comes to wounds.

Review of R313's progress notes did not show any documentation that family or doctor were notified of the 4/26/2023 change and worsening in wound condition.

R313 progress note dated 5/20/23 documents a change in condition and with shortness of breath that is different than usual.

(B)

2 of 2 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

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S9999	Continued From page 4 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. 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 Requirements were not met as evidenced by: Based on interview and record review the facility failed to provide safety by not following the mechanical lift manufacturer instruction. This failure resulted in R36 falling from a Mechanical	S9999		

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lift while under staff direct care sustaining multicompartmental intracerebral hemorrhage (ICH). The facility also failed to follow its policy in reporting, investigating and monitoring of resident who has unwitnessed fall, and ensure resident's environment is free of accident hazards.
This affected 3 of 5 residents (R36, R88, R100) reviewed for safety.

Findings include:

On 7/19/2023 at 12:09 PM, V25 (RN) said V32 (CNA) asked if she could help her transfer R36 into a dialysis chair with a Mechanical lift. V25 and V32 went to the resident room. V25 said that V32 was positioned on the resident right side and V25 was positioned on the resident left side. V25 said that V32 asked V25 to hook the purple loop onto the Mechanical lift hook. V25 said that she confirmed with V32 that all the purple loops are on all four sides of the Mechanical lift hooks. V25 said that the dialysis chair was positioned at the foot of the bed. V25 said that V32 elevated R36 up with the remote control. V25 said that once R36 was up, V25 went to the right side of R36 to guide her into the dialysis chair. V25 said that R36 was about 30 degrees above bed and was being moved towards the dialysis chair when R36 fell. V25 said that R36 body hit the floor first, and then R36 hit her head on the foot of the Mechanical lift. V25 said that V25 immediately assessed R36, called V11 (Wound Care Nurse) and V3 (Assistant Director of Nursing) ADON, and V11 and V3 also assessed R36. V25 said that V11 applied pressure on R36 head. V25 said that V3 and Wound Care Nurse stayed with R36 while V25 went and called 911. V25 said that V11 and V3 continued to stay with R36 and assessing her until 911 came and took R36 to the local hospital. V25 said that is possible that the

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resident slipped out of the sling because the loops were intact.

Mechanical lift manufacturer instruction that stipulates "when patient is elevated a few inches off the surface of the stationary object (wheelchair, commode or bed) and before moving the patient, check again to make sure that the sling is properly secured".

On 7/19/2023 at 12:41 PM, V3 (ADON) said that she was called to room by V25 (RN) and upon entering the room, V3 noticed that R36 was on the floor. V3 said that R36 was noted with laceration at the back of her head. V3 said that V7 (Wound Nurse) was also present, so V7 applied pressure to the back of her head. 911 took R36 to local hospital. R36 was diagnosed with multicompartmental intracerebral hemorrhage (ICH), including: Left frontal intraparenchymal hemorrhage (IPH), with surrounding edema and subdural hematoma (SDH), L temporal SDH and subarachnoid hemorrhage (SAH), Left parafalcine SDH.

On 7/20/2023 at 12:30 PM, V32 (CNA) said that V32 and V25 were transferring R36 to a dialysis chair using a Mechanical lift. V32 said that V32 and V25 confirmed all 4 purple loops were attached to the Mechanical lift hooks. V32 said that R36 fell from the sling while being transferred to the dialysis chair. V32 said that after the fall, she noticed that only 3 of the purple loops were intact. V32 said that she couldn't identify what caused the fall until the fire marshal came and inspected the Mechanical lift, then V32 said that V32 noticed that one of the metal lash was missing. V32 said that if she had noticed that a metal lash was missing prior to operating the Mechanical lift, she would have not used it and

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would have told V25 that they need to use another Mechanical lift.

07/20/2023 at 2:12 PM, V11 (Wound Care Coordinator) said that she was on second floor rounding when the floor nurse called V3 (Assistance Director of Nursing) and V11 into R36 room. V11 said that when she came to the room, R36 was on the floor with small amount of bleeding coming from back of R36 head and V11 applied pressure to the area where R36 is bleeding from until 911 arrived.

07/20/2023 at 2:24 PM, V2 said during her investigation, V25 (RN) and V32 (CNA) both said that used proper technique when transferring R36 with a Mechanical lift from her bed to dialysis chair. V2 confirmed that if the loops were properly secured, it might not gotten loose during the transfer. V2 said that the facility had an in-service in May which included all transfers. V2 said that right after the incident all clinical staff were in-serviced with return demonstration. V2 said that moving forward that all agency staff will be in-serviced to ensure that they are competent in transfer using Mechanical lift with return demonstrations and will be on-going.

R36 is a 65 year old female admitted on 4/12/23 with a diagnosis not limited to acute and chronic respiratory failure, dependence on respirator (Ventilator) status, dependence on renal dialysis, and hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease.

Facility Fall Prevention Program
Effective Date: 11-28-12
Department: Nursing, Therapy, Administration

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Revisions: 11-21-17
Purpose:
To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary.
Guidelines:
The Fall Prevention Program includes the following components:
" Adherence to manufacturer's recommendation in use of alarm and medical devices and special care equipment.
Battery Powered Patient Lift Manufacturer Instruction
Lifting Patient
WARNING
When elevated a few inches off the surface of the stationary object (wheelchair, commode, or bed) and before moving the patient, check again to make sure that sling is properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object (wheelchair, commode, or bed) and correct this problem.

On 7/18/23 at 12:20pm Observed R88 lying on scoop mattress. V19 LPN said that R88 is at high risk for fall and just fell recently.

On 7/19/23 at 9:58am, V7 Restorative Nurse (RN) said that she does the formulation and updating fall care plan. V2 DON does the initial investigation and root cause analysis after each fall. The floor nurse will do the fall incident documentation and report the incident. Review R88's medical record with V7 RN. V7 said that R88 is admitted on 1/5/23 with diagnosis listed in

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part but not limited to history of falling, Laceration to part of head due to fall, Vascular dementia. V7 said that admission fall assessment done on 1/5/23 indicated that R88 is at high risk for fall. V7 said that R88 has several incidents of unwitnessed fall namely: 2/1/23 - Unwitnessed fall. R88 observed sitting on the floor in his room. 5/15/23- Unwitnessed fall. R88 observed on prone position on the floor, bleeding on the left forehead. R88 was sent to hospital for suturing of laceration on left forehead. 7/14/23- Unwitnessed fall, R88 observed in supine position on the floor in his room. Informed V7 that on 7/11/23 at 4:54am documented by V30 RN on R88's progress notes indicated: Observed R88 sitting on the floor in his room. R88 denies any pain or headache, able to move all extremities and no shortening of his legs. R88's physician order dated 7/11/23 indicated: May send 911 to hospital emergency room due to fall. V29 Night shift Nursing supervisor documented that R88 strongly refused to go to the hospital. 911 paramedic staff and V29 spoke with R88's family member and refused R88 to be sent to the hospital. V7 said that she is not aware and was not notified that R88 had a fall incident on 7/11/23. V7 said that there is no fall investigation done regarding possible cause of R88's fall incident and fall care plan is not updated. V7 said that there is no fall incident done by V30 RN on 7/11/23.

On 7/20/23 at 7:21am, V29 Night shift Nursing Supervisor said that on 7/11/23 R88 had unwitnessed fall, he was found sitting on the floor in his room. R88's fall incident report is completed by V30 RN on 7/11/23. V29 said that she reported to V2 DON about R88's fall incident.

On 7/20/23 at 9:40am, V2 DON gave the fall incident report dated 7/11/23 done by V30 RN. V2

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said that she was not notified of the incident report not until 7/19/23. V2 said that she did not complete the fall investigation and update the care plan not until she just learned about it yesterday. V2 said that V30 RN did not put R88's fall incident report in the risk management so she did not see it.

On 7/20/23 at 11:30am, V7 Restorative Nurse said that she probably overlooks R88's fall incident report completed by V30 RN on 7/11/23.

Facility's policy on Incident and Accident indicates:
Policy: The incident/accident report is completed for all unexplained bruises or abrasions, all accidents, or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors, or other and resident-to-resident altercations.
Procedures: An incident/accident report will be completed for:
1. All serious accidents or incidents of residents
3. All unusual occurrences
1. An incident/accident report is to be completed by RN or LPN and is to include:
a. Date and time of an incident/accident
b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered and notification of appropriate parties.
4. Documentation on nurse's notes is to include:
a. a description of the occurrence, the extent of injury, the assessment of the resident, vital signs, treatment rendered, and parties notified.

Facility's policy on Fall prevention program indicates:
Purpose: To assure safety of all residents in the facility, when possible. The program will include

Illinois Department of Public Health

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measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Program will monitor the program to assure ongoing effectiveness.
Guidelines:
*Care plan incorporates: Addresses each fall, interventions are changed with each fall,
Standards:
*Accident/incident reports involving falls will be reviewed by the interdisciplinary team to ensure appropriate care and services were provided and determine possible safety interventions.

On 07/18/2023 at 11:20AM during observation, R100's bed was observed with plugged in power strip on the side of his bed leaning against the side rail with two chargers plugged on it and the cord coiled on the side rail. At 11:56AM, the above-mentioned was observed with V47 (Maintenance Assistant) and at 12:00PM, it was also observed with V15 (Maintenance Director).

On 07/18/2023 at 11:56AM, V47 stated that he has always seen R100's extension cord like that.

On 07/18/2023 at 12:00PM, V15 said that it should not be on the bed because it is not safe for the R100.

R100's order summary report dated 7/21/2023 indicated admission date of 01/14/2021 and diagnoses including anxiety disorder due to known physiological condition and major depressive disorder, recurrent, mild.

Facility Policy:
Title: Electrical Equipment

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S9999	Continued From page 12 Review Date: 11/2022 Power Strips: The following are the circumstances where power strips are allowed in the facility: 4. Power strips are prohibited in patient care vicinity and may not be utilized for other devices, such as: personal electronics. (A)	S9999		