STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003586	A. BUILDING: _____ B. WING _____	C 04/22/2023

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ELEVATE CARE NORTHBROOK	270 SKOKIE HIGHWAY NORTHBROOK, IL 60062

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S 000	Initial Comments Complaint Investigation 2392828/IL158380	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.696b) 300.696b)3) 300.696f)4) 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 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. f) Infectious Disease Surveillance Testing and Outbreak Response 4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment. These requirements were Not Met as evidenced by: Based on observation, interview, and record	S9999		

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S9999	Continued From page 2	S9999		

review, the facility failed to ensure adherence to infection control practices to prevent the transmission of the Coronavirus (COVID-19) as evidenced by failure to: 1) ensure a COVID-19 positive resident is not cohorted together in one room; 2) follow appropriate protective personal equipment (PPE) guidelines in the observation rooms for COVID-19 residents on contact and droplet precautions; and 3) failed to ensure that residents and their representatives are informed of the latest incidence of COVID-19 infections in the facility. This failure has a greater potential to affect R4 given his congregate nature, age, and underlying medical conditions.

Findings include:

1. R1 is an 80 year old male with the following medical history: Seizure, Brain lesion, Malignant neoplasm metastatic to brain, Metastatic squamous cell carcinoma, Open wound of scalp with complication, subsequent encounter, Tonic clonic seizures, Anemia of chronic disease, Chronic indwelling Foley catheter, Subacute osteomyelitis, other site, Bacteremia due to Enterococcus, Acute respiratory failure with hypoxia, Deep vein thrombosis (DVT) of lower extremity, unspecified chronicity, unspecified laterality, unspecified vein. R1 is non-verbal and is not interviewable. R1 was sent to the hospital on 4/3/2023 because of witnessed seizure episode and returned to the facility on 4/10/2023.

On 4/21/2023 at 11:30 AM, with V4 (Registered Nurse/RN), the door to R1's room was observed to be wide open, with a sign by the door stating, "Contact and Droplet Precautions". Personal Protective Equipment was available outside R1's room. R1 was observed in bed, appears clean and orderly. No intravenous access observed.

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S9999	Continued From page 3 When asked if he has any concerns regarding his care while in the facility, R1 did not respond. It was also observed that R4 is in the same room as R1. When asked if R4 is also positive for COVID-19, V4 stated that R4 is not positive for COVID-19. R1's Physician Order Sheet with an order date of 4/17/2023 documents the following orders: Isolation Precaution Contact and Droplet - due to COVID + result. On 4/21/2023 at 11:55 AM, V4 (RN) stated, "I am the regular nurse for R1 and R4. I don't think R4 knows that his roommate, R1 is positive for COVID-19. I didn't tell him that R1 is COVID positive. I think he should be transferred to a different room because the roommate is positive. Only R1 is positive for COVID. Because they are in the same room, R4 might get COVID from R1." When asked why he is in the same room as R1 when R1 has COVID-19 infection, V4 did not respond. On 4/21/2023 at 12:00 PM, interviewed R4 with V4 (RN). R4 had no mask on. R4 stated that facility has been testing him for COVID-19. R4 stated nobody informed him that his roommate tested positive for COVID-19, that nobody talked to him about being transferred to a different room and that he will not object to being transferred if needed because roommate tested positive for COVID. R4 stated nobody informed him about consequences of staying in the same room with somebody who has the COVID-19 infection. On 4/21/2023 at 3:00 PM, when asked if V1 talked to him about transferring to a different room on 4/17/2022, V4 stated, "She came here to tell me she did, but I don't remember it. Nobody educated me regarding COVID-19. I go to	S9999		

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S9999	Continued From page 4 dialysis; I cannot get sick from COVID. I don't think the dialysis center knows that I am with somebody who is positive for COVID." R4 is a 74 year old male admitted to the facility on 9/19/2022 with the following diagnoses: Anemia, unspecified, Atherosclerotic heart disease of native coronary artery without angina pectoris, Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, End stage renal disease, Orthostatic hypotension, Thrombocytopenia, unspecified, Chronic combined systolic and diastolic heart failure, Non-rheumatic aortic stenosis, Type 2 diabetes mellitus with diabetic neuropathy, unspecified, Candidiasis, unspecified, Other symptoms and signs involving the musculoskeletal system, Mixed hyperlipidemia, Obstructive sleep apnea, Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation, Personal history of COVID-19, Major depressive disorder, single episode, unspecified, and Essential hypertension. R4's Minimum Data Set with Assessment Reference Date of 3/29/2023 under Section C: Brief Interview for Mental Status documents a score of 15 which affirms that R1 has no cognitive impairments. On 4/21/23 at 1:30 PM, V1 (Administrator) stated R4 will be tested again today, and we will convince him to transfer to a different room. Later on, V1 stated that R4 was tested, and the result was negative and that R4 agreed to be transferred and will be moved to a different room as soon as possible. On 4/21/2023 at 1:37 PM, V3 (Infection Preventionist) stated, "We tested R1 for	S9999		

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S9999	Continued From page 5 COVID-19 upon readmission on 4/10/2023 and the result was negative. Then R1 was tested again on 4/13/2023 and 4/15/23 and it was both negative also. On 4/17/23, R1 was coughing, so R1 got tested again and the result was positive. On 4/17/23, it was a rapid test and results were received the same day. It is our policy for readmits to be tested upon readmission, on the 3rd day and 5th day. Since 4/10/2023 until today, R1 has been in the same room with R4, who does not have the COVID infection. We did not move R4 to another room. We are monitoring him for symptoms. We tested R4 right after we tested R1 which was on 4/17/23 and 4/19/23 and both results were negative. We still did not transfer R4 to a different room knowing R1 is positive because R4 is already exposed, we didn't move him." When asked why R4 was not transferred to a different room since roommate R1, tested positive on 4/17/23, V3 stated that because R4 is very much set in his ways and will not allow them to transfer R4 to a different room. V3 stated that V3 did not document that she talked to R4 regarding transferring to a different room, and there is no documentation of educating R4 regarding dangers and consequences of being in the same room as R1 who tested positive on 4/17/2023. When asked what the dangers of cohorting 2 patients are when R1 is positive for COVID and the other one, R4 is not positive for COVID-19, V4 stated, "There is a danger that the R4 can contract COVID-19 infection from R1 resident since they are in the same room." On 4/21/2023 at 12:50 PM, V1 (Administrator) stated, "I talked to R4, and he said he didn't want a room change, but he didn't want to be changed. As far as documentation, there is nothing documented that I talked to him regarding being transferred to a different room. R4 is alert and	S9999		

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oriented, but he tends to forget. I know that if it's not documented, it didn't happen, unfortunately we didn't document that we provided education to R4. Normally if we found out we talk to them multiple times." When asked how many times she spoke with R4 regarding room change, V1 stated she talked to him once. When asked if she documented somewhere in R4's medical records her conversation regarding education about COVID and need for room transfer, V1 stated, I didn't document it.

On 4/21/2023 at 3:00 PM, V1 (Administrator) presents a Concern and Grievance Log that affirms that somebody from Social Services Department spoke to R4 regarding need for room change and that R4 refused. V4 (RN) also stated that R4 was tested, and his result came back negative for COVID-19 and that they convinced R4 to move to a different room and will be moved right away.

Review of medical records affirm that R1 and R4 both have orders for Isolation Contact Precaution due to Colonized Candida auris, both were admitted with those infections. Only R1 tested positive for COVID-19. R4 tested negative on 4/17/23, 4/19/23 and 4/21/23. R4 was finally transferred to a different room on 4/21/2023.

Facility presented a policy with original effective date of 3/05/20 titled "Infection Control- Interim COVID-19 Policy" under Management and Care of Residents with Suspected or Confirmed COVID-19 Infection which documents: "If cohorting, only residents with the same respiratory pathogen should be housed in the same room."

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S9999	Continued From page 7 2. On 4/21/2023 at 12:00 NN, while outside room of R1, while surveyor was putting on Personal Protective Equipment/PPE with V4 (RN), V5 (family member) entered room of R1 and R4 without donning PPE. V4 was with surveyor outside the room of R1. V4 did not stop and instruct wife of R1 to don PPE. V4 stated, she had already told earlier V5 to wear gown and gloves. When asked, why V4 did not stop V5 from entering room without wearing proper PPE, V4 did not respond. When asked if somebody told her about the use of PPE, V5 responded, "No. I wasn't told. I don't know about that." V5 also stated that she is not aware of facility incidence of COVID-19 infections because nobody has informed V5 about the number of staff and residents who tested positive for COVID-19. Facility presented a policy with original effective date of 3/05/20 titled "Infection Control- Interim COVID-19 Policy" under Visitation of Residents in Transmission Based Precautions and During Outbreak which documents: For the safety of the visitor, in general, in-person visitation should be discouraged while the resident is in transmission-based precautions and during outbreak. However, the facility must still allow the visitations to occur while ensuring that the visitors are informed of the risks and measures to reduce risk of transmission as follows: Counsel residents and their visitor(s) about the risks of an in-person visit. Encourage use of alternative mechanisms for resident and visitor interactions such as video call applications on cellphones or tablets, when appropriate. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene,	S9999		

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S9999	Continued From page 8 limiting surfaces touched and use of PPE according to current facility policy. 3. On 4/21/2023 at 9:00 am, during entrance to the facility, a sign is posted in the front entrance door which states: "Last Known Positive Resident COVID-19 Case: 3/28/2023." On 4/21/2023 at 2:18 PM in the presence of V1 (Administrator), V3 (Infection Preventionist) further stated, "R1 was symptomatic on 4/17/23 that's why R1 was tested and readmitted. R1's result was positive on 4/17/2023. I did unit-based testing for staff and residents. Only residents in 1 East were tested, nobody tested positive. The residents and family members can look at the facility website to look for information regarding COVID-19 status updated. The residents are informed of COVID-19 updates via the postings in the entrance, elevator, day room, nurses' station, entrance, and exit doors." Surveyor informed her that the posting states that the last in-house positive case was on 3/28/23 but R1 tested positive on 4/17/2023. V3 stated, "Up to this day, 4/21/2023, I have not confirmed if R1 is an in house COVID positive, that's why the posting did not get updated. When asked if R1 and R2 were provided education, V3 stated, "When R1 tested positive, I educated him and the wife regarding the COVID-19 positive result. For R4, I wasn't able to educate R4 regarding COVID-19, its consequences of being in the same room with the resident who is positive. I asked help. V1 talked to R4. V1 (Administrator) provided the website where family members are updated regarding presence of COVID-19 in the facility: https://elevatecare.com/covid-19/. The website as of 4/21/23 lists Zero (0) under Current Positive	S9999		

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S9999	Continued From page 9 In-House COVID Residents and Zero (0) under Current resident PUI. V1 stated that V3 already submitted the facility report to the corporate office who is in charge of updating the website. As of 4/21/23, there is one resident (R1) who is positive for COVID-19 infection Facility presented a policy with original effective date of 3/05/20 titled "Infection Control- Interim COVID-19 Policy" under Communication to Residents, Representatives and Families which documents: "Inform residents, their representatives and families of those residing in the facilities by 5 pm the next calendar day following the occurrence of: - either a single confirmed infection of COVID-19, or - three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. (A)	S9999		