STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 07/12/2024

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ELEVATE CARE SOUTH HOLLAND	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

(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 Investigations 2493755/IL173110 2493651/IL172958	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.3240 a) 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	S9999		

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resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their practice and provide a staff escort to an appointment for a resident R1 diagnosed with dementia, BIMS (Brief Interview for Mental Status) score of 5, identified not capable of unsupervised outside pass privileges. R1 was dropped off by transportation company on 5/8/24 at approximately 2:00pm, unknown drop off point. R1 was later found by family in streets trying to self-propel over a curb ramp approximately 3:30pm. This affects 1 of 1 resident (R1) reviewed for supervision.

Findings include:

R1's face sheet denotes R1 has diagnoses of dementia, unspecified convulsions, anxiety disorder, and history of falls.

R1's MDS (Minimum Data Set), dated 3.29.24, section C for cognitive pattern denotes R1's BIMS score of 5 (cognitively impaired), section GG for functional abilities denoted mobility devices wheelchair is checked.

R1 community survival skills assessment, dated 3/29/24, denotes the resident is sufficiently alert

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oriented coherent and knowledgeable allowing him or her to be considered for independent outside past privileges, the box for no is checked. Outcome/ recommendations denotes, the resident does not appear to be capable of unsupervised outside past privileges at this time.

R1 most recent care plan, dated 5/24/24 denotes R1 has impaired cognitive function/dementia, or impaired thought process related to dementia. R1 is at risk for falls r/t (related to) decreased mobility, balance, and endurance.

Facility incident report, dated 5/8/2024, denotes, "incident no injury, during transportation, per resident daughter, resident did not make the appointment and was located outside the hospital and taken with her. Interviewed daughter and inquired of residents' well-being and per daughter resident uninjured. Mental status - orientated to person, orientated to situation. Level of consciousness, alert, mobility- wheelchair bound. Predisposing physiological factors- impaired memory, other. Predisposing situation factors- during transfer. Other behaviors, transport. Resident 73 y/o (year old) AA (African American) male who is alert and oriented to name and situation with confusion related to diagnosis of dementia with behavioral disturbance. PMH (Primary Medical History) includes, HTN (hypertension, HF (Heart failure) ischemic heart disease, HLD (high density lipoprotein), and anxiety. During transport to appointment, resident was not transported to office suite by driver, who cited that resident began to display behaviors on arrival and refused to share paperwork and did not know what suite appointment was located. Per resident daughter, resident did not make the appointment and was located outside the hospital and taken home with her. Investigation and

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review of facility practice regarding escort appropriateness to ensue."

V1 (Unit clerk) statement denotes, "10:00 AM (V12, Transportation Driver) called and asked if he can change R1 appointment time to 1:00 PM so he (V12) has time to get back south in time to pick up his other riders. I (V1) told him yes, if it was okay with the daughter who was meeting him at the appointment. 1:00 PM (V12) called facility to say he was about 20 minutes out. 1:04pm I (V1) called V11 (R1 family) and told her about the new pickup time. She said it was OK because she lives around the corner from there about five minutes away. Daughter stated since he will be there early, she will get him something to eat before he goes to his appointment at 3:45pm. I told her I will call her once the transport actually arrives and leaves our facility. 1:32pm I called (V11) and told her they picked up her dad and he's on his way to the appointment. 3:00 PM (V11, R1's family) called and told me he wasn't there. 3:15pm made my first call to (clinic name). I told them the daughter called and said her father (R1) was not at the appointment. (Medical Insurance company) then made their first attempt to contact the transportation company which I found out is (transportation company name). They were unable to reach them. I was told they were escalating it to the supervisor; I (V1) will get a call back. 3:45 PM I called the doctor's office to see if the patient had checked in, I was told he hadn't. 4:00 PM I called (V11), but I did not receive an answer. I called (clinic name) back and I stayed on the phone for about 45 minutes while the supervisor tried repeatedly to contact the transportation company as well as other supervisors. 4:45 PM I called doctor's office again and was told the office was closed and he had not checked in. 4:55 PM I received a call

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from the driver (V12) telling me he was on his way to pick up (R1), I explained to him the situation he told me that he dropped the patient off at (outpatient clinic address). That he went to the desk relations and spoke to a man named (name noted) in a red shirt and told he was dropping (R1) off and that his daughter was meeting him there. I stayed on the phone with him while he went in the building spoke to the guest relation person. They went to the 4th floor to see if (R1) or (V11) was there, and they were not. 5:30PM- 6:00 PM (V11) called the building and said she (V11) had (R1). I stayed on the phone with (V12) to see if he needed to go and pick him (R1) up from wherever they were. 6:00 PM I called (V11) to see if she wanted us to pick him up and she did not answer so I left a voicemail. Signed (V1)."

On 6/28/24 at 10:46 AM, V1 (Unit Clerk) said, "(R1) had a scheduled appointment, pick up time was at 2:45pm on 5/8/24. (R1's) appointment was on the 4th floor of the building. (R1) has managed Medicaid and the insurance schedules the residents' transportation. The driver called the facility and asked if he could pick (R1) up early so that his other clients were not late for their appointments." V1 said she got approval from R1 daughter for early pick up. V1 said she called R1 daughter when the driver picked R1 up because the daughter was going to meet R1 at the clinic for his appointment. V1 said she got a call from R1's daughter inquiring about R1 whereabouts because R1 had not made it to the appointment. V1 said she hung up and immediately called the insurance company because the insurance company scheduled R1's transportation. V1 said although the driver contacted her for early pick up, she did not have his contact information. V1 said she was able to contact the insurance

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company and they were calling the driver. V1 said she stayed on hold while the insurance company tried to contact the driver. V1 said she may have been on hold for more than an hour. V1 said she called R1's daughter back with no response. V1 said V13 (Assistant Director of Nursing) was aware of the situation. V1 said V13 did not give her any directives. V1 said she figured V13 was aware because she was standing around when she was on the phone with the daughter. V1 said around 4:55PM, V12 (Transportation Driver) called her and said he was going to pick R1 up for his scheduled pick up. V1 said that was unusual because the drivers never call and say they are picking up the residents. V1 said at that time she asked V12 where he dropped R1 off too, because R1's daughter said R1 did not make it to his appointment, and she could not find R1. V1 said V12 was not aware R1 did not make it to his appointment. V1 said V12 informed her that he took R1 inside the building and R1 was having behaviors and would not give him (V12) the paperwork to determine where he supposed to go. V1 said the driver did not contact the facility or her to inform them R1 was having behaviors. V1 said the driver should have contacted the facility if R1 was having behaviors and would not give the paperwork to determine R1's drop off location/point/destination. V1 said R1's daughter called her sometime after 5:30PM and stated she found R1. V1 said at that point, management was involved and she doesn't know the details surrounding where R1 was found. V1 said the drive to R1's appointment was about 20-minute drive. V1 said she doesn't know if the driver escorts the residents to the clinic or just to the entry door of the building. V1 said she doesn't know the process. V1 said she doesn't know who should know the process.

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On 6/28/24 at 12:39 PM, V11 (R1's family) said on 5/8/24 around 9:00 AM, V1 (Unit clerk) called her and confirmed R1's appointment and confirmed she will be meeting R1 at the appointment. V11 said V1 called her back at 11:00AM, and stated the driver will be picking R1 up at 1:00PM instead of 2:45PM because he had multiple clients to pick up and did not want them to be late for their appointments. V11 said she was agreeable. V11 said V1 suggested that she (V11) wait for R1 on the fourth floor where the scheduled appoint was planned. V11 said she arrived at the appointment, and she waited. V11 said time passed and R1 never arrived. V11 said she asked the receptionist if R1 had checked in, and was informed R1 had not checked in. V11 said she waited because she was aware the driver had other clients to drop off and or maybe they were running late. V11 said the appointment time had arrived and R1 was not there. V11 said she went downstairs to look for R1 and she did not see R1. V11 said she called the facility and spoke to V1 to inquire about R1 whereabouts. V11 said V1 informed her R1 was picked up and she would call the insurance company so they could contact the driver. V11 said she went back to the clinic building to look for R1; she did not see R1. V1 said she began to worry, and her nerves were bad because she did not know where her father was. V11 said she got in her car to look for a local convenience store to buy cigarettes to calm her nerves, V11 said there was a lot of traffic, the cars were at a standstill. V11 said as she got closer to the intersection, she saw her father crossing the street in his wheelchair, trying to self-propel over a curb ramp. V11 said the cars was honking their horns for R1 to get out the way. V11 said she immediately got out her car to help R1. V11 said R1 was upset stating "the driver just left me". V11 said she called 911 but

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they never arrived. V11 said she later got a call from the driver stating \he was going to pick R1 up from his appointment. V11 said she informed the driver he will not be picking R1 up because she did not trust R1 in the care of that driver. V11 said she took R1 home. V11 said she was very upset about the situation. V11 said the facility should have sent R1 with a staff escort because R1 has dementia, and R1 could have been hurt. V11 said R1 told her the driver just left him. V11 said she doesn't think the driver took R1 inside the clinic building. V11 said R1 should not be in the community alone, R1 has dementia. R1 could have been hit by a car.

On 6/28/24 at 12:11PM, V14 (Insurance company rep) said the transportation drivers do not take clients inside of facilities for scheduled appointments; the drivers do not register clients for their appointments. V14 said the driver can open the door to the clinic if they choose to do so. V14 said the expectation is drop off /pick up only.

On 6/28/24 at 1:52PM, V15 (transportation company) said the transportation company provide curb to curb service only, drop off and pick up. V15 said the drivers do not take clients inside of the buildings/ facilities. V15 said it's for insurance purposes. V15 said escorts can accompany the client during the trip. V15 said he recommend clients are escorted during a trip. V15 said V12 is no longer with the company; he is not available for interview. V15 said he doesn't recall the situation with R1.

On 6/28/24 at 2:00PM, V4 (Director of Nursing) said she was aware R1 did arrive to his appointment. "The facility investigated and concluded (R1) should not have gone to an appointment without a facility staff escort. (R1)

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has dementia and his community survival assessment show he can not be in the community alone. Due to the incident, the facility has put practices in place."

On 7/2/24 at 11:55AM, V13 (ADON- Assistant Director of Nursing) said V1 (unit clerk) did not inform her R1 did not arrive to his appointment; V1 did not inform her R1's daughter called the facility concerned about R1's whereabouts. V13 said she was passing by V1 going to the "standdown meeting", and she heard V1 on the phone and made a statement "what do you mean you can't find your father". V13 said she did not stop to inquire about what she heard because V1 was on the phone and could have been discussing anything. V13 said R1's situation was not discussed in the "standdown meeting". V13 said she was not aware of the situation. V13 said after the meeting, she did her task of ensuring the facility had enough staff on duty because there was a call off. V13 said some time after 5:30PM, she was made aware R1 was found, and that's when she learned R1 did not arrive to his doctor's appointment. V13 said the Director of Nursing was involved at that time. V13 said V1 did not inform her of the situation with R1 missing from his appointment. V13 said V1 should have informed her, the DON, or the charge nurse immediately. V13 said she would have contacted management and initiated the missing resident protocol. V13 said V1 should have not tried to handle that situation by herself.

On 7/2/24, V4 (Director of Nursing) said she was made aware of R1 not arriving to his scheduled appointment on 5/8/24 sometime after 5:30PM. V4 said V1 did not notify her when she was initially notified of R1 being missing, and she (V1) should have notified her immediately.

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S9999	Continued From page 9 On 7/2/24 at 1:34PM, V16 (Licensed Practical Nurse/LPN) said she was R1 nurse on 5/8/24 for the morning shift, and she was not aware R1 did not make it to his appointment and R1 was missing. V16 said she became aware of this today because staff was standing around talking about. On 7/2/24 at 3:51PM, V17 (Registered Nurse) said she was R1 nurse on 5/8/24 for the evening shift. V17 said no one informed her that day R1 did not arrive to his scheduled appointment and R1 was missing. V17 said someone did inform her R1 would not be returning to the facility after his appointment; she documented that. Facility missing resident/elopement policy, with last review date of 11/15/2018, denotes all personnel are responsible for reporting a cognitively impaired resident attempting to leave the premises or suspected of missing to the charge nurse as soon as practical this includes any resident that did not sign out on pass and or did not notify a staff member of his or her leaving. Should an employee discover that a resident is missing from the facility he or she should immediately report the missing resident to the charge nurse or nursing supervisor. Review physician order to determine if the resident is out on an authorized leave or pass. Alert staff by announcing code green over the paging system. Inform staff of the name of the resident and visualize pictures of resident if available. Make a thorough search of the building and the premises. Notify administrator and director of nursing immediately if the resident is not found after the search the administrator and director of nursing will evaluate the situation and develop a plan of action based on the individual resident.	S9999		

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S9999	Continued From page 10 (A) 2 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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		

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

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their fall prevention protocols by not completing an accurate fall risk assessment evaluation, failed to implement individualized interventions related to the root cause of falls to minimize the risk, and failed to implement fall prevention interventions. This affected two of three residents reviewed for fall and fall preventions. These failures resulted in R3 falling from a wheelchair with no non-skid pad applied. R3 sustained a laceration to the left eyebrow resulting in sutures.

The findings include:

1.R3's diagnoses include, but are not limited to, Epilepsy, Hypertension, Convulsions, and Alcohol Use. R3's cognition is documented on 4/23/24 as severely impaired.

R3's physician orders includes orders for daily administration of Escitalopam (antidepressant) and Clonazepam (benzodiazepine). R3's

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Medication Administration Record documents R3 received the ordered medications on 5/20/24 and 5/25/24.

R3's behavior assessment, dated 4/23/24, documents he has no behaviors.

Review of R3's falls include falls on 5/20/24 and 5/25/24.

R3's notes on his fall report of 5/20/24 documents interventions to minimize the potential for falls non skid pad to his wheelchair.

R3's notes on his fall report of 5/25/24 documents interventions includes non skid pad to wheelchair. Fall requires suture repair.

R3's care plan denotes 5/23/24 non skid pad to the wheelchair.

R3's progress notes, dated 5/25/24, documents R3 returned from emergency room. R3 noted to have seven sutures over his left eyebrow. R3 has steri strip/ wound closures across the bridge of his nose.

R3's hospital records, dated 5/25/24, documents R3 presents status post fall complaining of a 2cm laceration to middle of R3's forehead. Upon chart review this is the second fall within the past week as the patient had a fall two days ago when he was seen in the hospital. Face location: Nose Length: 2cm. Steri-strips and sutures (sutures for forehead laceration and strips for nose laceration).

Facility Reported Incident report from 5/26/24 documents R3 had a fall and was sent to the emergency department for evaluation and

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ELEVATE CARE SOUTH HOLLAND	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

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received sutures to left brow area.

On 6/28/24 at 12:40PM, V2, Licensed Practical Nurse (LPN) said R3's falls are related to his confusion. V2 said, "(R3) had one fall from his wheelchair and the Aide, (V6), was taking (R3) to from the lobby into the dining room. (R3) fell forward. (R3) did not have his feet on the wheelchair pedals or have pedals on his wheelchair." V2 said R3 got sutures on the upper eyelid. V2 said, "(V6) said to me, (R3's) feet got stuck." V2 said R3 was not able to pedal himself in the wheelchair before the fall; he was dependent on staff.

On 6/28/24 at 1:04PM, V5, Certified Nursing Assistant/CNA, said, "(R3) can stand and pivot and he is on fall precautions. (R3) wears hipsters, a helmet, and is kept in common area when he is in his chair. (R3) gets restless and he is alert and confused. (R3's) fall prevention interventions are on the closet door." V5 showed the surveyor the closet with a document that includes hipsters, helmet, keep in common area, and non slip pad for wheelchair. At 1:09 PM, V5 stood R3 up. R3 was sitting on a wheelchair cushion, but no non slip pad on the seat on or under the wheelchair cushion.

On 6/28/24 at 1:11PM V6, CNA, said, "I was getting (R3) to take him into the dining area from the sitting area. (R3) was sitting in his wheelchair in the sitting area. When I moved (R3), he dropped his feet and fell forward; he hit his head. (R3) was dependent on me to move him in the wheelchair; he could not move it himself.

On 6/28/24 at 1:03PM V4, Director of Nursing, said, "(R3) had seizures with some of his falls. The next time (R3) fell, he became very

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confused. I think all of (R3's) falls surround his seizures and dementia. (R3) is not educatable, not redirectable, and we try to protect him from injuring himself. The CNA was pushing (R3) in the wheelchair and he was able to follow commands, but he put his feet down and fell."

On 7/2/24 at 12:55PM, V10, Nurse Practitioner, was asked what medications can place residents at risk for falls. V10 replied, "Antihypertensives, Narcotics, Benzodiazepines, and Antidepressants. Midodrine can place a resident a risk because of changes in blood pressure. Clonazapam is a Benzodiazepine. Lexapro is an Antidepressants. Both trade names or generics can be a risk. The nurses should know these medications can cause increased risk of falls for the residents."

2.R2's diagnoses include, but are not limited to Atrial Fibrillation, Acute on Chronic Diastolic (Congestive) Heart, Multiple Myeloma Not Having Achieved Remission, Anemia in Chronic Kidney Disease, End Stage Renal Disease, Type 2 Diabetes Mellitus, Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5, End Stage Renal, and Moderate Protein Calorie Malnutrition.

R2's fall scale evaluation, dated 2/7/22, indicates the resident has never fallen; a score of 51. R2's fall scale evaluation, dated 2/22/24, indicates the resident has never fallen; a score of 26. Low risk is identified as a score of 0-24; moderate risk 25-44; high risk 45 or more.

Review of R2's physician orders includes orders for daily administration of Escitalopam (antidepressant) and blood pressure regulating medications (Cardizem, Midodrine, and

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Metoprolol Tartrate). Review of R2's Medication Administration Record documents R2 received the ordered medications on 2/22/24.

Progress Notes written by V8, dated 2/22/24, documents, "resident observed on the floor in room in a sitting position. Patient is awake and alert follows direction but could not state how she fell. Appears weak."

Fall report, dated 2/22/24, documents R2 on the floor in room in a sitting position. Blood pressure 142/73; heart rate 108; Oxygen saturation 91%; Temperature 101. Weakness was indicated as predisposing factor. Root cause analysis, dated 2/23/24, stated R2 sent to the hospital and will be reviewed upon return. Remind to use her call light, upon return.

Progress Notes written by V8, dated 3/19/24, documents, "resident observed on the floor in room during nursing rounds by RN. Resident lying on floor in left lateral position."

Fall report, dated 3/19/24, written by V8 documents R2 was observed on the floor during nursing rounds. Blood pressure 130/64; heart rate 66; temperature 101.4; oxygen 89% placed on oxygen. Root cause analysis dated 3/20/24 documents following chemotherapy and dialysis R2 has weakness.

R2's care plan, initiated on 3/19/24, states "call don't fall" added on 2/23/24.

On 6/28/24, V7, Restorative Nurse, said, "For hygiene, toileting, dressing, and transfers, (R2) required 1 person assist. For bed mobility, (R2) was able to complete that with supervision. (R2) was able to participate in her cares. If a resident

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falls, we might look at root cause analysis." V7 read the root cause documented on R2's fall report, dated 3/19/24. V7 said R2 denied falling, if she fell she could not remember. V7 read the resident received chemotherapy and dialysis. V7 said R2 had been placed in bed immediately after treatment. V7 said, "The follow up interventions were draw labs, urine culture, place floor mats, use a low bed, and place the call don't fall sign. (R2) had weakness." V7 said before 3/19/24, R2 had no falls. V7 said, "The fall prevention interventions were the basics, keep everything in reach. For safety on everyone we say keep everything in reach, keep call light in reach, falling leaf for high risk." V7 said R2 was not on the falling leaf program. V7 said R2 was not high risk upon admission for falls. V7 said R2 had a fall on 2/22/24. The surveyor asked V7 if R2's fall scale evaluations are accurate. V7 said she can't answer for the nurse completing the evaluation.

On 6/28/24 at 3:23PM, V8, Registered Nurse/RN, said, "On 3/19/24, (R2) was observed on the floor during rounds. She was status post chemo and had returned to the facility. The last time I saw her, before the fall, she was in the bed. I found (R2) on the floor. Generally, (R2) did not use the call light often. This was (R2's) first fall that I was aware of. After a fall occurs we put new measures in place."

On 7/2/24 at 9:54AM, V4, Director of Nursing, said, "I was not employed here when (R2) fell on 2/22/24." At 10:08AM, V4 said the cause of R2's fall on 2/22/24 was being symptomatic and anemic. V4 said, "Symptomatic means (R2) was having shortness of breath, dizziness, and weakness. Specifically (R2) was experiencing weakness and then she received dialysis earlier that day, which caused more weakness."

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S9999	Continued From page 17 On 7/2/24 at 11:43AM V7, Restorative Nurse, was asked what medications may place R2 at risk for falls. The surveyor presented V7 R2's physician orders. V7 said, "I can't answer that, I would have to look them up to know the side effects." The Fall Prevention Program, dated 11/28/12, states, "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. Care plan incorporates Identification of all risk issues; addresses each fall; interventions are changed with each fall as appropriated; preventative measures." (B)	S9999		