STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006647	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE WAUKEGAN	2222 AUDREY NIXON BOULEVARD WAUKEGAN, IL 60085

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S 000	Initial Comments Complaint Investigation 2418032/IL178849	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1035 e) 300.1210 b) 300.1210 c) 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 300.1035 Life-Sustaining Treatments e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to have an effective process in place for staff to quickly identify a resident's code status. The facility failed to immediately provide cardiopulmonary resuscitation (CPR) to a resident (R1) found not breathing and pulseless, whose POLST (Physician Orders for Life-Sustaining Treatment) form showed the resident was a Full Code. These failures led to a delay in R1 receiving CPR and R1 dying in the facility. These failures apply to 1 of 6 residents (R1) reviewed for deaths in the facility in the sample of 6.

The findings include:

R1's care plan, dated 7/18/24, showed R1 was a cognitively impaired resident with diagnoses of dementia, cerebral infarction (stroke), dysphagia, and schizophrenia. R1 was dependent on staff for all cares. The care plan showed R1 was a Full Code and wanted full treatment/CPR in the

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event of a cardiac arrest. The plan showed R1 "wishes for full code status, as specified in their advanced directive documents, will be honored and clearly delineated in the medical record ..."

R1's POLST form, dated 1/25/24, showed R1 was a Full Code. Staff were to attempt CPR and provide all indicated treatments to R1 in the event of a cardiac arrest. The form was signed by V6 (R1's Physician) and R1's legal guardian.

A physician order for R1, dated 8/29/24, showed R1 was a Full Code.

R1's nurses note, dated 9/20/24, showed R1 was found unresponsive and pulseless in his room by staff at 6:29 PM. V7, Registered Nurse (RN), started CPR on R1 and 911 was called. EMS (Emergency Medical Services) arrived at the facility at 6:35 PM and took over providing CPR to R1. R1 was pronounced dead in the facility at 7:10 PM.

R1's death certificate, dated 9/20/24, showed R1's cause of death as cardiopulmonary arrest.

On 10/7/24 at 9:45 AM, V5, Certified Nursing Assistant (CNA), stated she fed R1 dinner on the evening of 9/20/24. V5 stated, "(R1) was fine at dinner. I fed him in his room while he seated upright in his Geri Chair (reclining wheelchair). When I went back to check on him, about a half hour later, he didn't look right. He was still sitting in his chair. His eyes were open. I called out his name and he didn't respond. He didn't look at me. I didn't check to see if he was breathing. I don't know if he had a pulse. I didn't know what to do. I left the room to go find the nurse (V7, RN). I found the nurse (V7) in another resident's room and asked him to come look at (R1). (V7)

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walked down to (R1's) room with me. He checked for a pulse on (R1) and tried to get (R1) to respond. (V7) then walked out of (R1's) and said he had to go check to see what (R1's) code status was. (V7) went to the nurses station and checked (R1's) code status on the computer. (R7) came back into the room and started CPR on (R1) because he said (R1) was a Full Code." V5 stated she was CPR certified, but did not check R1 for a pulse or yell for help when she found R1 unresponsive because, "I didn't know what to do. I was nervous." V5 stated from the time she entered R1's room and found him unresponsive, to the time V7 (RN) started CPR on R1, was "probably at least a few minutes. We had to get (R1) up out of his chair to do CPR." When V5 was asked how to quickly identify a resident's code status, V5 stated, "I don't know. I would have to ask the nurse."

On 10/7/24 at 10:21 AM, V7, RN, stated on 9/20/24, he was in another resident's room when V5 (CNA) came to find him. V7 (RN) stated, "(V5) asked me to come look at (R1) because she said he didn't look right. I got up and went down to (R1's) room. He was up in his wheelchair. He was not responding to me. I tried to feel for a pulse on him, but I couldn't feel one. I didn't know if he was a Full Code or not, so I went out to a computer at the nurses station to check. I saw in the computer (R1) was a Full Code. I went back in to his room and tried to feel for a pulse again. I didn't feel a pulse on (R1), so I called a code and started CPR on him." V7 stated, "If I don't know a resident's code status, I have to check their medical record on the computer at the nurses station."

On 10/7/24 at 9:59 AM, V6 (R1's Physician) stated, "If a resident, that is a full code, is found

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pulseless and not breathing, staff are to start CPR on the resident immediately." V6 stated a delay in CPR "could cause death." V6 stated he did not know any details surrounding R1's death in the facility, but stated, "I just know he died of cardiac arrest."

On 10/7/24 at 11:20 AM, V3 (Director of Nursing/DON) stated, "If staff find a resident unresponsive and the resident is a Full Code, they should check for a pulse and start CPR immediately. Staff are not to leave the resident. They are supposed to shout for help." V3 stated, "There really isn't a quick way to verify the code status of a resident. Staff either have to check the chart in the computer or check the DNR (do not resuscitate) lists we have located in the binders on the crash carts on the floors."

On 10/7/24, V4, Licensed Practical Nurse (LPN), V8 (LPN), and V9 (LPN) each stated the only way to verify a resident's code status is by leaving the resident's room to check their electronic medical record via computers located at the nurses stations.

On 10/7/24, V10 and V12 (CNAs) each stated they did not know how to check a resident's code status. V10 and V12 each stated they would have to ask a nurse to verify a resident's code status.

The facility's Cardiopulmonary-CPR policy, dated 3/22/22, showed, "The facility will provide basic life support, including CPR, when a resident requires such care, prior to arrival of EMS, subject to physician order, and resident choice indicated in the resident's advanced directives ...CPR Procedure: Check for resident response while simultaneously assessing the resident for

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S9999	Continued From page 5 breathing and pulse for 10 seconds. Shout for help and activate the emergency response system by announcing overhead, 3 times, "code blue" and the location of the code..." (AA)	S9999		