STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: ______ B. WING ______	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE RIVERWOODS	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

(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 Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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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S9999	Continued From page 1	S9999		

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:

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 identify pressure ulcers prior to becoming advanced stages for 2 residents (R47, R97). This failure resulted in R97 developing a stage 3 pressure ulcer. The facility failed to have preventative measures in place for a resident (R8) with a stage 4 pressure ulcer, failed to implement wound treatment for 2 residents (R26, R47), failed to provide pressure ulcer prevention measures for a resident (R35), failed to accurately assess a wound for 1 resident (R97), failed to assess a reopened, advanced stage pressure ulcer for 1 resident (R26). These failures apply to 5 of 9 residents reviewed for pressure ulcers in the sample of 30.

The findings include:

1. R97's electronic face sheet printed on 7/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 2	S9999		

showed R97 has diagnoses including but not limited to hypertensive chronic kidney disease, end stage renal disease, dependence on renal dialysis, type 2 diabetes, morbid obesity, peripheral vascular disease, and pressure ulcer of left buttock stage 3.

R97's facility assessment dated 5/15/24 showed R97 has no pressure ulcer injuries.

R97's skin risk assessment dated 5/29/24 showed R97 is at risk for skin breakdown.

R97's Wound Assessment Details Report dated 7/16/24 showed, "Trauma/Abrasion, facility acquired, left buttocks, 1x1x0cm (centimeters)."

R97's Wound Assessment Details Report dated 7/19/24 showed, "Pressure Ulceration Stage 3, facility acquired, left buttocks, 1x2.3x0.2cm, light serosanguinous (thin, yellow/pink) drainage."

On 7/25/24 at 1:18PM, V4 (Wound care nurse) stated, "(R97's) pressure ulcer is new for her, it is not a reopened pressure ulcer. I wasn't the one who assessed her wound. The person who assessed it is no longer here. I don't think she really knew how to assess wounds very well. (R97) should have never developed a stage 3 pressure ulcer. She is very compliant with offloading and repositioning and gets her showers regularly so this definitely should have been identified prior to a stage 3. I know that she was having some loose stools for a bit but I can't even say that is an excuse for her developing the ulcer. Hers should have been identified prior to a stage 3 for sure. It was initially assessed as an abrasion which was incorrect. Once the wound physician saw (R97) it was correctly assessed and proper treatment was initiated. There is no way this was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: ______ B. WING ______	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S9999	Continued From page 3	S9999		

ever an abrasion. It is clearly on an area where there is pressure so it should have been assessed as that 'from the get go.' Skin assessments should be done during perineal care, dressing, bathing, etc. Anytime they are able to observe skin they should be checking it. Shower days are best days because they have a whole view of the resident's body. It is important to identify wounds early for the best chance to heal a wound. New wounds need to have treatment initiated immediately to prevent worsening or infection or delay."

The facility's policy titled, "Pressure Injury and Skin Condition Assessment" dated 1-17-18 showed, "Purpose: To establish guidelines for assessing, monitoring, and documenting the present of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented...3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse...11. A wound assessment for each identified open area will be completed and will include...c. stage of pressure ulcer..."

2. R26's electronic face sheet printed on 7/25/24 showed R26 has diagnoses including but not limited to chronic embolism and thrombosis of left femoral vein, peripheral vascular disease, alcoholic cirrhosis of liver, morbid obesity, and dementia without behaviors.

R26's facility assessment dated 4/26/24 showed R26 has 1 stage 3 pressure injury.

R26's physician's orders from (local wound center) dated 5/14/24 showed, "Pressure injury posterior thigh and right buttock Stage 3 cleanse with normal saline, apply skin prep and Enluxtra,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: ____ B. WING ____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE RIVERWOODS	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

(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
S9999	Continued From page 4	S9999		

cover with mepilex border foam daily."

R26's May 2024 physician's orders showed, "5/21/24 Wound care: right buttock-cleanse with normal saline, pat dry, apply Enluxtra/skin pep to peri-wound, cover with mepilex bordered foam dressing." (7 days after R26's wound physician ordered the treatment)

R26's wound assessment dated 5/20/24 showed, "Pressure ulceration stage 3, right buttock, facility acquired, 0.5x0.5cm with scant, serous (clear/yellow) drainage." (This assessment was completed 6 days after R26's wound reopened).

On 7/25/24 at 1:18PM, V4 (wound care nurse) stated, "(R26) has 2 pressure wounds- 1 is on his posterior right thigh and 1 on his right buttock. He doesn't follow recommendations, and these are both ongoing pressure wounds. His right buttock has healed and reopened. Staging for a reopened wound has to be staged as it was before. His was a stage 3 and reopened so we had to stage it as a stage 3. The nurse that received the orders and assessment from the wound center should have notified the wound team right away when his buttocks was determine to have reopened so that we could do an assessment and implement orders."

3. R47's face sheet showed she was admitted to the facility on 12/6/2022 with diagnoses to include hypertensive chronic kidney disease, dementia with behavioral disturbance, generalized osteoarthritis, osteoporosis, hyperlipidemia, and peripheral vascular disease. R47's facility assessment dated 5/9/24 showed she has severe cognitive impairment and is dependent on staff for all cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: ______ B. WING ______	07/25/2024

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ELEVATE CARE RIVERWOODS	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

(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
S9999	Continued From page 5	S9999		

R47's care plan initiated 12/31/24 showed, "[R47] has pressure injury to sacrum, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to: Dementia, Chronic Kidney Disease, Hypertensive Chronic Kidney Disease, bradycardia, generalized osteoarthritis, osteoporosis... contractures, fragile skin, immobility, incontinence of bowel, and incontinence of urine... Interventions... Treatments as ordered by provider..."

R47's initial wound assessment dated 12/31/23 showed a facility acquired stage 3 pressure ulcer to R47's sacrum measuring 1.5 cm x 1.0 cm x 0.1 cm.

R47's December 2023 eTAR (electronic Treatment Administration Record) showed an order started 12/31/23 showed "Wound Treatment to Sacrum; cleanse area with normal saline pat dry and apply medihoney and cover with foam dressing every 24 hours as needed. This order was not documented as completed on 12/31/23 on the December 2023 eTAR. R47's January 2024 eTAR showed a new order dated 1/5/24 for "Wound Treatment to Sacrum; cleanse area with normal saline, pat dry and apply medihoney and cover with foam dressing every day shift for wound care." There was no evidence of dressing changes being completed for R47's sacral wound from 1/1/24 through 1/4/24.

On 7/25/24 at 11:12 AM, V2 DON (Director of Nursing) said to identify new skin issues the staff should be doing skin assessments with all cares such as incontinence care, showers, and activities of daily living.

On 7/25/24 at 2:10 PM, V4 RN (Registered Nurse) said it is important to identify wounds

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S9999	Continued From page 6	S9999		

quickly and get interventions and treatments added immediately so the wound does not get worse.

4. On 7/24/24 at 7:58 AM, R8 was sitting up in bed, with the head of her bed at 90 degrees. R8 had an over the bed tray table in front of her. At 8:50 AM and 11:54 AM, R8 was sitting up in bed with her head of the bed at 90 degrees. There weren't any positioning devices in place. At 11:54 AM, R8 was asked if anyone had turned her or repositioned her in bed today and she replied, "No." At 12:56 PM, R8 will in the same position she was in at 7:58 AM, 8:50 AM, and 11:54 AM. R8's alert and oriented roommate (R27) stated no one had been in to reposition R8 all morning.

On 7/24/24 at 2:11 PM, V4 RN (Registered Nurse/Wound Care Director) stated R8 has a pressure ulcer to her sacrum and should be repositioned every two hours.

The Wound Assessment Details Report dated 7/19/24 for R8 showed she has a stage 4 pressure ulcer to the sacrum that is 1 cm x 4 cm x 1.50 cm (L x W x D).

R8's Care Plan dated 5/29/24 showed, R8 has a pressure injury to her sacrum.... Foam wedges for proper offloading. Turn and position the resident per physician's orders.

The MDS (Minimum Data Set) dated 5/29/24 for R8 showed moderate cognitive impairment; substantial/maximal assistance needed for rolling left and right; dependence for transfers.

The facility's Pressure Ulcer Prevention (1/15/18) showed, turn dependent resident approximately every two hours or as needed and position

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: ______ B. WING ______	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE RIVERWOODS	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

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S9999	Continued From page 7	S9999		

resident with pillow or pads protecting bony prominences as indicated.

5. On 7/24/24 at 8:48 AM, R35 was dressed and sitting in her wheelchair in her room with a tray table in front of her. R35 had a thin pressure relief cushion in place to her wheelchair. The cushion did not come to the front edge of wheelchair seat; the cushion was approximately 1 inch back from the edge.

On 7/24/24 at 12:00 PM, R35 was sitting in her wheelchair at the dining room table for lunch. R35 had a thin pressure relief cushion in place to her wheelchair. The cushion did not come to the front edge of wheelchair seat; the cushion was approximately 1 inch back from the edge. V20 (R35's daughter) was feeding R35 and stated, she has not been notified of any pressure ulcers. After lunch they will lay her down due to her pressure ulcers in the past. R35 usually gets pressure to her buttocks. V20 stated she would appreciate it if they would call her and let her know when R35 has a pressure ulcer.

On 7/24/24 at 1:20 PM, V9 LPN (Licensed Practical Nurse/Wound Nurse) changed the dressing to R35's left buttock wound. There was scarring to R35's left buttock and a small, slit like opening to her left buttock. V9 stated the pressure ulcer was either a stage one or stage two and is open. V9 stated she would need to look in the computer for the stage of the pressure ulcer. V9 was shown the pressure relief cushion in R35's chair that was flattened, worn in appearance, and positioned approximately 1 inch back from the edge of the wheelchair. V9 measured the cushion and stated it was 4 cm thick. R35 stated the wheelchair cushion should come out to the edge of the chair and should be

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	IL6001119	A. BUILDING: ______ B. WING ______	07/25/2024

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S9999	Continued From page 8	S9999		

Continued From page 8

thicker.

On 7/24/24 at 1:59 PM, V4 RN (Registered Nurse/Wound Care Director) stated for pressure relief cushions in wheelchairs the staff should be looking for signs of wear and replace the cushion. The cushion should fit the chair.

The Wound Care Physician Note dated 7/18/24 for R35 showed, follow up left buttock wound - re-opened; stage 3 pressure; 0.5 cm x 1.2 cm x 0 cm; 100 % non granulating tissue with defined margins. Date reported - 7/18/24. Preventative measures in place - low air loss mattress, heel offloading being done, turning schedule present, wheelchair cushion. Assessment and Plan: Pressure ulcer of left buttock, stage 3. Clean with normal saline, apply medicated petroleum dressing and dry dressing. Plan of care: Upright incline limit to 30-45 degrees for prolonged period of time, when there is a risk for ischial pressure, unless patient can reposition. Wheelchair cushion or custom molding when sitting and re positioning as needed. Please limit wheelchair for maximum of 2 hours at a time.

The Nurse Pressure Injury Assessment dated 7/16/24 showed a left posterior stage 3 pressure ulcer that was first identified on 7/16/24 when bathing/showering.

The Face Sheet dated 7/25/24 for R35 showed diagnoses including Parkinson's disease, hypertension, diabetes mellitus, hyperlipidemia, osteoarthritis, and hypothyroidism.

The MDS (Minimum Data Set) dated 5/28/24 for R35 showed moderate cognitive impairment; dependence for transfers; and substantial/maximal assistance for rolling left and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 9 right. (B)	S9999		