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 _____	C 10/19/2023

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

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S 000	Initial Comments Complaint Investigation Survey #2398447 / IL165355 #2398394 / IL165287 #2397779 / IL164526 Facility Reported Incident of 8/23/23 #IL164239	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 1. 300.610a) 300.1210b) 300.1210d)6 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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 Requiremnts were not met as evidenced by: Based on interview and record reviews, the facility failed to include documentation in the residents medical record of assessment and monitoring of tracheotomy status and cares provided. This failure affected one (R7) of one resident reviewed for tracheotomy care and resulted in R7 being found unresponsive, with tracheotomy tube not in place and the facility was not able to identify how long the resident was without the trache tube in place; R7 expired of respiratory distress.	S9999		

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S9999	Continued From page 2 Findings include: R7 is a 76-year-old female, admitted in the facility on 03/14/2022 with diagnoses of Chronic Respiratory Failure, Unspecified, Unspecified Whether with Hypoxia or Hypercapnia and Encounter for Attention to Tracheotomy. Nurse Practitioner progress notes dated 03/14/22 recorded that R7 was alert and oriented to time, place, person and event. She was able to write and mouth out words as a way of communication. She had a tracheotomy tube in placed to oxygen source. According to progress notes dated 04/04/2022 time stamped 8:30 AM, V6 (Respiratory Therapist, RT) documented that around 7:25 AM, she was called to come to R7's room. As she entered the room, R7 appeared to be dusty and unresponsive. Code blue was called, and CPR (cardiopulmonary resuscitation) began. V6 observed in R7's left hand her trache. Another RT (V24) entered the room and replaced the trache and started ambu bagging the resident (R7). CPR was continued until paramedics entered and took over. Progress notes dated 04/04/2022 time stamped 9:00 AM, R7 expired at 8:20 AM. On 10/17/23 at 11:17 AM, V6 was asked regarding R7. V6 stated, "I remember she had her trache in her hand. I did start CPR immediately and chest compressions. I don't know how the entire trache got to her hand. When I started CPR, V24 (Respiratory Therapist) inserted the same trache to get an airway. The trache ties were there, one part is open and the	S9999		

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S9999	Continued From page 3 other part still has the tie. I might say that she pulled it and it came out, not sure. She was alert and oriented. She had anxiety. She could have been redirected or notify nurse that she is anxious so PRN (as needed) medication for anxiety could be administered." V6 was also asked on what could be the cause of her (R7) death. V6 verbalized, "Because she did need oxygen and she removed it, then it could be the cause of her death, which is due to lack of oxygen." On 10/18/23 at 12:24 PM, V24 (Respiratory Therapist) was interviewed regarding R7 but denied any knowledge regarding R7 and incident. However, in progress notes dated 04/04/22 time stamped 12:03 PM, V24 documented R7 was found unresponsive, CPR was done for 50 minutes. V5 (Licensed Practical Nurse, LPN) was also asked regarding R7. V5 replied, "That time, I already saw her lying down, unresponsive. We tried to talk to her but she was not responding. We started CPR. After paramedics arrived, they checked her. And after one to two hours, they said she (R7) expired. Respiratory Therapist does trache care and changing of trache. They don't have a specific time, they do it as needed. As a nurse, I monitor resident's trache when doing rounds in the morning, when I started my shift, and during med pass. I checked trache every two hours or less. When I came that morning, I saw her unresponsive already. I was morning shift that time. Usually, after night shift gave report around 7 AM, I do my rounds." R7 was found unresponsive around 7:25 AM as progress note documented. There was no other documentation noted pertaining to R7's condition prior to 7:25 AM, unable to determine how long she (R7) was unresponsive.	S9999		

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S9999	Continued From page 4 On 10/17/23 at 1:14 PM V16 (Respiratory Therapy Director) was interviewed regarding trache monitoring. V16 verbalized, "Residents can remove their own trache. If it is a resident who continuously remove the trache or tubing, Nursing Department is informed so mittens could be used on those residents. Trache removal usually happens on residents who are very anxious, having periods of restlessness; when they have anxiety episode, they can remove the trache. Staff has to do frequent monitoring, if staff observed a resident having anxiety, let nurses know so PRN medication can be administered. If a resident is alert and conscious, staff has to redirect them and reeducate on the importance of trache in breathing process." Further review of R7's progress notes showed no documentation related to any anxiety episodes. Her (R7) face sheet listed "Anxiety Disorder, Unspecified" as one of the diagnoses. POS (Physician Order Sheet) dated 03/15/22 indicated that R7 had an order of Alprazolam tab 0.25mg (milligrams) - give 1 tablet via Gtube (gastrostomy tube) every 12 hours as needed for anxiety. MAR (Medication Administration Record) recorded that Alprazolam was administered to R7 on 03/23/22 and 03/31/22 only. R7's care plan on tracheotomy documented: Intervention (03/23/22) - Monitor for s/s (signs and symptoms) of respiratory distress (restlessness, agitation, confusion, increased heart rate (tachycardia), air hunger and / or bradycardia. On 10/17/23 at 2:10 PM, V10 (Nurse Practitioner, NP) was interviewed regarding R7. V10 stated, "She was alert, oriented to time, place, person and event; very pleasant lady. She was	S9999		

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S9999	Continued From page 5 diagnosed with acute hypoxemic and hypercapnia respiratory failure. When she was at the facility, she needed a trache collar to oxygen source. She felt anxious on and off. When I saw her last 03/28/22, she felt that she was having slow progression in mobility and she wanted to get disconnected from trache and oxygen. She wanted to get back to normal life." V10 was also asked about the importance of trache in R7's condition. V10 stated, "If she cannot breathe and not getting adequate oxygenation, she would clearly not do well and need a trache." R7's Death Certificate dated 04/05/2022 documented: Date of death: 04/04/2022 Causes: Respiratory Failure On 10/18/23 at 9:37 AM, V20 (NP/Pulmonology) was asked regarding tracheotomy care and respiratory failure. V20 stated, "Residents with respiratory failure is not able to breathe on their own, they have tracheotomy placed on them to assist with breathing. It is a system that helps residents breathe on their own. The lungs cannot get enough oxygen in the blood, and not able to breathe out their carbon dioxide which is a waste gas. If trache is removed and no oxygen, you don't breathe, you die. Staff needs to make sure trache is in place, make sure the resident is alive and breathing. Staff needs to monitor residents for breathing and tracheotomy placement. Residents can still remove the trache when they are confused, or accidentally remove the trache when they scratch the neck. If residents are anxious, it is possible that they can also remove their trache." Facility's policy titled "Tracheostomy Care", undated, does not specifically address	S9999		

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S9999	Continued From page 6 procedures or guidelines on trache monitoring and management. "A" 2 of 2 Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 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 7 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 were not met as evidenced by: Based on interviews and record reviews the facility failed to follow their policy and procedures for fall prevention by not identifying and implementing personalized care plan interventions on admission and not providing adequate supervision for a resident at high risk for falls; they also failed to adequately supervise or remove a safety hazard when identified, for a resident at high risk for falls. These failures applied to two of three residents (R5 and R6) reviewed for falls and resulted in R5 sustaining a head injury requiring sutures. Findings include: R5 is an 84-year-old male with a diagnoses history of Prostate Cancer, Bone Cancer, Mild Cognitive Impairment, Major Depressive Disorder, Anxiety Disorder, and Cognitive Communication Deficit who was admitted to the	S9999		

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S9999	Continued From page 8 facility 08/09/2023. R5's Hospital Record dated 08/09/2023 and included in the facilities electronic medical record documents he is a high fall risk with interventions implemented including: place of bed locked in lowest position, bed alarm set, side rails up times three, and frequent rounds maintained. R5's Fall Risk Assessment dated 08/09/2023 documents he was at moderate risk for falls. R5's current care plan initiated 08/10/2023 documents he is at high risk for falls related to confusion, being unaware of safety needs, hearing problems, and history of falls with interventions including: Review information on past falls and attempt to determine cause of fall, record possible root causes, alter remove any potential causes as possible, educate resident/family/ caregivers/ interdisciplinary team as to causes; effective 9/1/23 anticipate resident's needs, offer toileting before bedtime or during night shift when awake, encourage resident to use assistive device, therapy to screen; physical therapy to evaluate and treat as ordered or as needed; does not include low bed as an intervention. R5's current care plan initiated 08/18/2023 documents he displays socially inappropriate and maladaptive behavior as manifested by wandering aimlessly and leaving room Disrobed; These symptoms are related to mild cognitive impairment with interventions initiated 10/06/23 including: Use frequent reassuring phrases to help minimize feelings of fear and anxiety. Statements such as "You are safe with me," "You are okay," "You are in good hands," and "You and I are old friends" will help instill a feeling of security and, in turn, should minimize incidents of maladaptive behavior. R5's	S9999		

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S9999	Continued From page 9 current care plan initiated 10/06/2023 documents he exhibits movement behavior that may be interpreted as aimlessly roaming, wandering his unit, and wandering into peers rooms; behaviors are related to the diagnoses of Mild Cognitive Impairment of Uncertain or Unknown Etiology, poor safety awareness, and problems understanding the immediate environment with interventions including: Make rounds/room checks to minimize chance of unauthorized leave. R5's Nurse Practitioner progress note dated 8/9/2023 5:24 PM documents history of present illness (obtained from previous medical records and patient) patient is an 84-year-old male with past medical history of metastatic to bone prostate cancer, cognitive impairment, depression, anxiety, and delirium, who was admitted to the hospital on 8/2/23 with agitation/aggressive/erratic behavior and required soft restraints; was subsequently transferred to nursing facility for skilled nursing and rehab. R5's progress note dated 9/1/2023 03:13 AM documents: Heard a noise from patients room, CNA (Certified Nursing Assistant) went to check and call the nurse on duty. Patient was observed sitting by his bed bleeding at the back of his head, patient is alert and verbally responsive. 911 called. left message to V10 (Nurse Practitioner). R5's progress note dated 9/6/2023 3:44 PM documents: Removed three sutures. Facility Reported Incident Final Investigation Report dated 09/07/2023 documents on 09/01/2023 at 2:15 AM R5 had an unwitnessed mechanical fall inside his room; Assigned nurse observed R5 sitting on the floor by the edge of his bed; Observed with bleeding from the back of his	S9999		

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head; When asked what happened, R5 stated he wanted to go to the bathroom to urinate, ambulated without using his walker, lost his balance and fell; R5 sustained a head injury, was sent to Lutheran General Hospital emergency room for further evaluation of head injury and staples to his head wound and was readmitted back to the facility at 10:59 AM; The facility concludes that the root cause of R5's fall included unsteady gait, impulsiveness related to cognitive impairment and poor safety awareness prompting him to overestimate his ambulatory ability; R5 returned to the facility from the emergency room with three staples which will be removed in one week. Care plan was reviewed to include nursing interventions of prompted toileting, anticipate his needs, remind to use assistive device, physician, and family aware of investigation; R5 is interviewable and alert and oriented times two.

R5's progress note dated 10/2/2023 08:49 AM documents Patient seen and examined in room. Patient currently walking around room comfortably putting on his clothes. Patient has shown improved ambulation and strength but just limited by poor cognition and safety awareness.

Facility Reported Incident Final Investigation Report dated 10/12/2023 documents on 10/06/2023 the facility received a complaint from R5's family claiming he was neglected, V9 (Family Member) reported he observed R5 in the bed with no sheets or clothes on during a weekend visit but could not specify when; multiple interviews with staff who worked with R5 from 10/02/2023 - 10/04/2023 included reports of him often attempting to get out of bed and in doing so hitting his elbows on the side rails, attempting to use the bathroom without calling for assistance, attempts to walk on his own and being redirected,

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and having a continual behavior of taking off his clothes and incontinence brief with staff constantly having to redress him; On 10/04/2023 V10 (Nurse Practitioner) noted in his progress notes: R5 had been hospitalized 08/02/2023 for agitation, aggressive/erratic behavior and required soft restraints and was transferred to the facility for skilled nursing rehab; on 09/01/2023 R5 had a fall, hit the back of his head, lacerated his scalp, was sent to the hospital emergency room and returned the same day to the facility with staples to the back of his head; was being seen on 10/04/2023 for follow up and was observed to be more confused than usual, agitated, requires assistance with transfers and overall observed with weakness and confusion, was observed with scratch marks/skin abrasions that are self-inflicted when he hits side rails, table, etc; R5's care plan was reviewed and documents he displays socially inappropriate and maladaptive behavior as manifested by wandering aimlessly and leaving room disrobed and these symptoms are related to mild cognitive impairment.

R6 is a 76-year-old male with a diagnoses history of Seizure, Traumatic Subdural Hemorrhage, Dementia without Behavioral Disturbance, History of Falling, Unsteadiness on Feet, Lack of Coordination, Abnormalities of Gait and Mobility, and Abnormal Posture who was admitted to the facility 02/12/2021.

Observed R6 in his room lying down in his bed fully clothed with his bed in low position, observed a falling leaf next to his name outside his room. R6 stated he had a fall but didn't have to have any stitches or anything and had no scratches or scrapes from it. Observed a walker and wheelchair in the corner of R6's room. R6 stated

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S9999	Continued From page 12 the wheelchair and walker are not his and he has neither. R6's current care plan initiated 02/13/2021 documents he is at high risk for fall, is alert with periods of confusion, was admitted related to post Fall with Subdural Hematoma and multiple fractures and other Medical diagnoses of hypertension, depression, stroke, Senile Dementia; R6 is able to ambulate but with unsteady gait and resident is on medication Anti-seizure, Antidepressant and Anti-Hypertensive with interventions including: Evaluate fall risk on admission and as needed. R6's Quarterly Fall Assessment dated 07/20/2023 documents he does not use any ambulatory aids and is at high risk for falls. R6's progress note dated 8/23/2023 7:37 PM documents: At 4:25 pm, staff reported to writer that resident had a witnessed fall incident in the unit. Investigation initiated. On interview staff reported that they noticed resident standing by the nurses station with his cane. Staff noted the resident took several steps back and lost balance. Head to toe assessment done, bleeding noted on back of head, area cleansed with and covered with gauze. Resident could not explain what prompted him to step backwards. Resident was transferred via 911 to hospital emergency room for further evaluation; at 8:58 PM Called hospital for follow up, resident will be admitted with diagnosis of Head Bleed. Facility Reported Incident Final Investigation Report dated 08/24/2023 documents on 08/23/2023 at 4:25 PM staff reported to V2 (Director of Nursing /Registered Nurse) that R6 had a witnessed fall on the unit; Interviewed staff	S9999		

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S9999	Continued From page 13 reported they noticed R6 standing by the nurses station and observed he took several steps back and lost his balance; R6 could not explain what prompted him to step backwards. Upon further review staff reported R6 was observed holding a cane which was not appropriate and was not included in the plan of care; Cane was removed from R6's room; R6 was readmitted from hospital, care plan was reviewed and revised with new interventions including screening and evaluation for physical therapy and occupational therapy. R6's progress note created by V10 (Nurse Practitioner) dated 8/29/2023 11:38 AM documents: Patient seen and examined today post readmission; on 8/23/23 patient was sent to the hospital after a fall, patient struck the back of his head and sustained a traumatic subdural hematoma, he was closely monitored and treated. Patients back of head small skin alteration is clean, dry, and intact. On 10/18/2023 at 11:01 AM V2 (Director of Nursing) stated R5's strength improved before he left the facility and was able to dress himself. V2 stated R5 was a high fall risk. V2 stated any review of past falls and root cause analysis information would be included in a fall risk management report. V2 agreed the purpose of reviewing past falls and developing a root cause analysis is to identify any personalized interventions that may be needed for a resident. V2 stated she uses the Morse fall evaluation and the nurse fall observation to assess if a resident is high risk for falls. V2 agreed an admitting residents hospital records are reviewed for fall history information and this information would be applied to the resident's care planned fall interventions. V2 stated V27 (Family Member) visited with R5 frequently and the facility does not	S9999		

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 _____	C 10/19/2023

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

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S9999	Continued From page 14 rely on family to supervise residents. V2 stated R5's behaviors do put him at risk for falls. V2 stated the facility cannot provide one on one supervision daily because it is not sustainable. V2 stated rounds are conducted every two hours and as needed. V2 stated as needed indicates when staff is done working with another patient, they can go back to R5 even if it was sooner than two hours. V2 stated R5 may not necessarily need one on one supervision but does require increased supervision which is not currently part of his care plan. V2 stated most of the time R5 wore a gown and did not wear a robe. V2 stated the term disrobing in R5's care plan indicates removal of any clothing the resident is wearing. V2 stated R5's history of needing soft restraints while in the hospital prior to admitting to the facility indicates he could be restless or impulsive. V2 stated she cannot explain what specific interventions could have been in place to prevent R5's unwitnessed fall 09/01/2023. V2 stated R5's decision making limitations, and overestimation of his abilities related to his cognitive impairment contributed to his fall on 09/01/2023. V2 stated although R5 was receiving rehabilitative therapy he still required the use of an assistive device to ambulate. V2 stated a low bed might have minimized the risk of R5's fall. Observed V2 read R5's care plan and confirmed it did not include low bed as an intervention. V2 stated impulsiveness does include getting up an attempting to ambulate without asking for assistance as it was documented when he fell on 09/01/2023. V2 stated when R6 fell in August staff were present. V2 stated if staff observed R6 using a cane and was not approved to use one they should have taken it from him. V2 confirmed due to it not being appropriate for R6 to use a cane, him using one did contribute to his fall.	S9999		

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S9999	Continued From page 15 The facility did not provide a risk management report for R5 and R5's medical records did not include a nurse fall observation. The facility's Fall Prevention Program Policy reviewed 10/18/2023 states: The purpose of the policy is "To assure the safety of all residents in the facility, when possible. The program will include implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary." "The Fall Prevention Program includes the following components: Methods to identify risk factors, Use and implementation of professional standards of practice." "Care Plan incorporates: Identification of all risk/issue, preventative measures." "Safety interventions will be implemented for each resident identified at risk." "The admitting nurse and assigned CNA (Certified Nursing Assistant) are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible fore ensuring ongoing precautions are put in place and consistently maintained." "The bed will be maintained in a position appropriate for resident transfers." "The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care." "B"	S9999		