Illinois Department of Public Health

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 ______	C 09/14/2021

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 Complaint 2116617/IL138003 - F689 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

and assistance to prevent accidents.

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to ensure a bed side rail remained secure during incontinence care for 1 resident (R1) reviewed for safety. This failure resulted in R1 falling out of bed and sustaining a cervical spine fracture, scalp laceration, and multiple skin tears.

The findings include:

On 9/14/21 at 9:20 AM, V1 (Administrator) said R1 fell from bed while receiving incontinence care. V1 said the side rail R1 was using for support, "Collapsed." V1 believed R1 pressed the emergency release button causing the side rail to unlock and slide to the down position. V1 added the bed rail was working prior to the fall and after the fall.

On 9/14/21 at 9:37 AM, V3 (Certified Nursing Assistant) said he was providing incontinence care to R1 on 9/6/21 at 10:15 PM. According to V3, R1 was in bed and turned to his right side. R1 held onto the right bed side rail for support. V3 said when he was placing a clean adult incontinence brief on R1, V3, "Heard" the side rail that R1 was using for support go to the down position. V3 said R1 then fell out of bed onto the floor. V3 said after the fall, R1 was bleeding and V3 yelled for the nurse to call 911. V3 said the side rail that R1 used for support was in the locked position at the start of incontinence care. V3 thought R1 pushed the emergency release

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S9999	Continued From page 2	S9999		

button that was located under the side rail causing the side rail to unlock and go to the down position.

On 9/14/21 at 9:59 AM, V4 (Registered Nurse) said he was the nurse taking care of R1 when R1 fell. V4 said as a result of the fall R1 sustained a skin tear to R1's leg, arm, and head. V4 said R1 was sent to the emergency room.

R1's Emergency Department Encounter documentation dated 9/6/210 showed R1 presented to the emergency room after having a bed rail give way causing a fall. R1's CT scan results showed an, "Acute fracture" of the C6 and C7 vertebra. The same documentation showed, R1 had a, "Large scalp laceration down to the bone" and laceration to the right leg and skin tears to both elbows.

R1's progress note dated 9/7/21 showed R1 was admitted to the hospital with a cervical spine fracture.

On 9/14/21 at 12:19 PM, V8 (R1's Nurse Practitioner) said she did not believe R1 had osteoporosis (weakening of the bones). R1's electronic medical record did not include the diagnosis of osteoporosis.

R1's Post Fall Observation form dated 9/6/21 showed, "[R1] stated that the right side rail just suddenly [dropped] down on the side of the bed that is why he fell."

R1's brief interview for mental status done on 7/2/21 showed R1 was cognitively intact.

R1's Minimum Data Set (MDS) dated 7/2/21 showed for bed mobility R1 required extensive

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S9999	Continued From page 3 assistance of staff, "Resident involved in activity staff [provided] weight bearing support." The same MDS showed R1 was total dependent on staff for incontinence care/toileting. (A)	S9999		