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
	IL6002851	A. BUILDING: ___ B. WING ___	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

(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 Recertification and Licensure Survey Complaint Investigations 2181895/IL131972 and 2181976/IL132069	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.675 3)4) Section 300.675 Covid-19 Emergency Rule Training Requirements 3). Facilities shall ensure 100% of the frontline clinical staff have completed the CMMS Training by February 28, 2021. 4). Facilities shall require, within 14 days after hiring, CMMS Training for all frontline clinical staff hired after January 31, 2021. These requirements were NOT met as evidence by: Based on interview and record review the facility failed to ensure compliance with training requirements (CMS Targeted for COVID-19 Training for Frontline Nursing Home Staff and Nursing Home Management) for staff and new hires. This failure has the potential to affect all 69 residents in the facility. Findings: On 3/31/2021, surveyor reviewed facility training binder and did not find a certificate of completion	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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 1	S9999		

for Nursing Home Management for V2 (Director of Nursing) and V36 (Admissions Director), with a completion date within 14 days of hire date.
On 3/31/2021 surveyor reviewed facility training binder and did not find a certificate of completion for Frontline Nursing Home staff for V32, V33, and V37 (LPN's) and V18, V19, and V34 (CNA's), with a completion date by 2/28/2021.
On 3/31/2021 at 8:55 AM V2 stated, "No, but I may have completed while working at a sister facility." V2 submitted certificate of completion for Frontline Nursing Home staff and Nursing Home Management with a date of 3/31/2021.
On 3/31/2021 at 2:45 PM V1 stated, "No, we are not at 100% of the required training."
On 4/01/2021 at 11:00 AM, V34 stated she completed the training, but there was no certification of completion in the binder for her.

(C)

2 of 3

300.610 a)
300.1210 b)
300.1210 d)1)

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

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	IL6002851	A. BUILDING: ____ B. WING ____	04/01/2021

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S9999	Continued From page 2	S9999		

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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that one resident (R13) in the sample received anti-itching medications as ordered. This failure affected R13 whose anti-itching cream was not applied, and a wrong dose of Benadryl was administered, for one (R13) of 34 sample residents reviewed for improper nursing care. This failure resulted in R13 crying and itching with red bumps (welts) on her skin, and unable to participate in daily activities

Findings include:

A. On 3/29/21, R13 was noted in the room scratching her body, pacing up and down the bedside, and crying. R13's arms and stomach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 3	S9999		

area were visibly noted with multiple red raised bumps (welts). R13 lifted up her top and multiple red raised bumps (welts) with streaks of blood across the bumps were observed on R13's stomach. R13 told the surveyor the blood is from her scratching. R13 told the surveyor 2 tablets of Benadryl (anti-itching medication) was ordered by her physician, but the nurse identified as V9, LPN (Licensed Practical Nurse), gave her only one pill. R13 stated V9 told her that she was just seeking drugs. R13 stated two tablets of Benadryl 25mg (each) always relieve the itching, and she can go about her daily activities. R13 then picked up a medicine cup with an unidentified whitish powder in the cup, and started applying the substance on the bumps (welts), and underneath the breast area. R13 stated it (referring to the whitish powder) was given to her by one of the nurses. When this observation was brought to V9's attention, V9 told the surveyor R13's case is a different one. V9 further stated R13 is a drug seeker, and a known drug abuser, whose medication includes Methadone. V9 stated he administered one pill of 25mg Benadryl to R13 at 9:00 AM, and it was not effective for R13. V9 repeated again "(R13) is just a drug seeker".

Review of R13's EMAR (Electronic Medication Administration Record) and Physician Order Sheet (POS) with V9 showed there is an order for Diphenhydramine HCL (Benadryl) Tablet 25mg (Milligram), with instruction to give 2 tablets by mouth every 8 hours as needed for itching. V9 did not document anywhere in the EMAR or progress note any anti-itching medication was administered at 9:00 AM. When this was shown to V9, V9 replied, "I forgot to sign it out". The surveyor then asked V9 to read the physician order. V9 stated, "I should have given her 2 (two) tablets of Benadryl. I will give the remaining one

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S9999	Continued From page 4	S9999		

tablet and document it". V9 signed at 10:26 AM he gave 2 (Two) tablets, and it was ineffective. R13 later expressed relief of the itching, thanking the surveyor for following up on the medication dosage.

On 3/29/21 at 10:41 AM, surveyor interviewed with V2 DON (Director of Nursing) in regards to facility expectation for licensed staff administering medication and following physician orders. V2 replied, "The nurses are expected to administer medications as ordered and give the medications following the five R's (referring to Right resident, Right dose, Right medication, Right route and Right time.)"

R13's plan of care documented under focus, R13 has actual skin impairment, and goals include R13 not developing any new breakdown, and intervention includes but not limited to, following treatment per MD (Medical Doctor) order.

On 4/1/21 at approximately 11:47 AM, in a telephone interview with V31 (Physician), V31 was asked if a resident's anti-itching medication, Benadryl 25mg tablet order, calls for two tablets to be administered, and is it acceptable for the nurse to administer one tablet. V31 stated, in part, "When a medication is ordered, if the order says one to two tablets the nurse can give one or two tablets using his or her judgement, but if the order specification is for two tablets, the nurse must give two tablets, not one or three or four tablets".

The facility policy on Medication Administration, with revised date 1/1/2015, presented documented that "Medication must be administered in accordance with physician order that includes but not limited to the right dose.

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	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 5	S9999		

Residents may self-administer medication if the interdisciplinary team has determined that this practice is safe." The policy listed out steps to follow if a medication error occurs by the licensed nurse, that includes but not limited to, immediately notify the physician, describing the error, and the resident response in the nurse's notes.

The facility Job Description for both RN (Registered Nurse) and LPN (licensed Practical Nurse) presented stated, in part, "The RN and LPN are responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained. "
Essential duties and responsibility includes, but not limited to, preparing and administering medication as ordered, charting in nurse's note in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care and perform routine charting duties as required and in accordance with established charting and documentation policies and procedure.

(B)

3 of 3

300.610 a)
300.690 b)
300.690 c)

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
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S9999	Continued From page 6 300.1010 h) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	S9999		

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S9999	Continued From page 7	S9999		

Continued From page 7

summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to timely notify a physician or nurse practitioner of a resident's continued right ankle pain, swelling, and bruising,

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S9999	Continued From page 8	S9999		

failed to implement their written policy to identify, investigate, and report an allegation of pain after a transfer with staff assistance, failed to timely identify and report to the State Agency an injury of unknown origin, and failed to thoroughly investigate of an injury of unknown origin for one (R68) of 34 sample residents reviewed for improper nursing care. These failures resulted in the delayed diagnosis of R68's right ankle fracture and timely hospital evaluation for R68 requiring an open reduction, internal fixation surgical repair of R68's right ankle.

Findings include:

R68 is an 82 year old with diagnoses that include cardiac arrhythmia, neuralgia and polyosteoarthritis. R68's Minimum Data Set (MDS), dated 2/5/21, documents, in part, that her Brief Interview for Mental Status (BIMS) is scored as 7, which indicates cognitive impairment.

R68's Minimum Data Set (MDS), dated 2/5/21, indicates R68 transfers, or how she moves between from the wheelchair to the bed, with "extensive assistance" where staff provide weight bearing support during the transfer while using "two persons physical assist."

In a progress note, dated 2/25/21 at 3:01 AM, V20 (Nurse Practitioner, NP) documents, in part, "(R68) reports left (L) ankle pain status post (s/p) transferring from wheelchair (w/c) to bed yesterday."

In a progress note, dated 3/1/21 at 9:50 AM, V20 documents, in part, that R68 reports "right (R) ankle pain," had "positive (+) R ankle swelling" and "+ lateral R ankle bruise" that was "discussed with nurse on duty (NOD) ... Whenever needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ____ B. WING ____	04/01/2021

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 9 (PRN) Acetaminophen and Ibuprofen available. Inform NP/Attending Physician (AP) if (R68) refractory to medication or bruising/swelling fail to improve." R68's census indicates that on 3/1/21, R68 was in a room on the second floor of the facility. Facility document, titled "Daily Nursing Schedule", dated 3/1/21, documents the second floor nurse from 7:00 am to 3:30 pm was V11 (Registered Nurse, RN). On R68's "Skin Condition Report,", dated 3/18/21 at 10:49 AM, V13 documented, in part, "swelling and bruise" under "abnormal" and circles R68's right ankle on the anterior side of a body diagram. R68's "Radiology Results Report," dated 3/19/21, documents, in part that the right ankle X-rays, 2 views, indicates "bimalleolar fracture dislocation of the right ankle." R68's hospital records indicated on 3/22/23, R68 had an open reduction, internal fixation surgery to repair the right ankle fracture diagnosed in the facility on 3/19/21. R68's electronic medication administration record, dated March 2021, documents, in part, that R68 was administered 7 doses of Ibuprofen 400 milligrams by mouth from 3/14/21 to 3/17/21. Facility document, dated 3/24/21, and titled, "Final Incident Investigative Report," V1 documents, in part, "The following facts were determined: ... (R68) reported a woman laid her down and her foot started to hurt. (R68) stated the woman hurt her foot ... Based on the known facts, the following conclusions have been determined about the original allegation: (R68) was	S9999		

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	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 10	S9999		

re-interviewed after her return to the facility. (R68) remains alert and oriented x2-3 and cooperative and is unable to recall if a staff member was providing ADL transfer and repositioning inappropriately or foot accidentally hit against a hard object."

On 3/30/21 and 3/31/21, this surveyor requested from V1 and V2 (DON) for any further investigative interviews or notes for R68's injury of unknown origin investigation. On 4/1/21 at 11:33 AM, V2 stated the four interview sheets V1 already provided the surveyor are the completed interviews done for R68's investigation of the right ankle fracture. On these four facility documents, titled "Witness Statements," V1 performed interviews with V2, V3, V5 (CNA) and V9 (LPN).

On 3/29/21 at 10:40 AM, R68 stated on an unknown date, "not enough people were helping me" when she was being transferred from the wheelchair back to bed, and she needs two staff members to help transfer her. R68 stated she had pain to her right ankle, and then had to go to the hospital for surgery because her right ankle was broken.

On 3/30/21 at 11:35 AM, V9 (LPN) stated on 2/25/21, he did not recall R68 complaining of left leg pain from an incident during a staff transfer. V9 stated, "I was busy that morning carrying out the new orders from (V20, Nurse Practitioner, NP)" for R68's low oxygen levels, and he then "transferred (R68)" to be quarantined. V9's progress note, dated 2/25/21 at 1:49 PM, does not mention R68 complaining of left leg pain from an incident during a transfer with staff.

On 3/30/21 at 2:36 PM, V13 (Wound Care Coordinator) stated on 3/18/21, V2 (Director of

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 11	S9999		

Nursing, DON) asked her to evaluate R68 for bruising and swelling to her right ankle. V13 stated R68's right ankle was observed with a bruise that was yellow with hints of brown and non-pitting edema. V13 stated she filled out the initial assessment report. V13 stated for any skin alteration, the staff nurse is to report it to her and she will do a full head to toe assessment as part of her investigation.

On 3/31/21 at 10:05 AM, V3 (Infection Preventionist) stated she was asked by V9 (Licensed Practical Nurse, LPN) to assess R68 on 2/25/21 for displaying a respiratory symptom of low oxygen saturation levels. V3 stated upon assessing R68 on 2/25/21, R68 complained of left leg pain that happened from staff transferring her "the night before" when R68 was moved from her wheelchair to the bed. V3 stated she did not view R68's left leg at this reported time. V3 stated she immediately informed V9 of R68's left leg pain from a staff transfer, and V9 told her "it was already taken care of." V3 stated on 2/25/21, she did not inform V1 (Administrator) of R68's left leg pain from a staff transfer.

On 3/31/21 at 11:35 AM, V11 (RN) stated she doesn't recall V20 (NP) "telling me anything" on 3/1/21 about R68's right ankle swelling or bruising. V11 stated she did notice that R68's legs looked "puffy" and R68 had "discoloration" to her right ankle. V11 stated she medicated R68 for generalized pain as reported by R68. V11 stated if she sees any bruises or swelling on a resident, she will report it to the Director of Nursing (DON), do an incident report, and notify the resident's doctor and family. V11 stated she did notice that R68's legs looked "puffy" and R68 had "discoloration" to her right ankle. V11 stated she did not notify V1 or V2 with this information,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ____ B. WING ____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 12	S9999		

and she was not interviewed by V1 for the investigation of R68's right ankle fracture. On 3/1/21, no nursing progress note was noted by V11 documenting R68's right lateral ankle bruising.

On 3/31/21 at 1:32 PM, V2 (DON) stated if a resident is requiring more pain medication than normal, the nurse must question "why would pain be worse and not getting better?" V2 stated the nurse must report this finding to the physician. V2 stated nurses must notify a physician of any change in a resident's condition. V2 stated a change in condition would include swelling, bruising or "anything that is not within the normal parameters or normal baseline for the resident."

On 3/31/21 at 4:00 PM, V1 (Administrator) stated on 2/25/21, she was not informed by any of her staff about R68's left ankle pain after a staff transfer from the wheelchair to the bed. V1 stated upon her performing a record review for R68's right ankle fracture diagnosed on a 3/18/21 X-ray, she did see V20's progress note on 2/25/21 about R68's initial report of pain after a staff transfer. V1 stated she didn't remember being told on 2/25/21 of R68's report pain after a staff transfer and that "the ball could have been dropped."

On 3/31/21 at 4:00 PM, V1 (Administrator) stated when an injury of unknown origin is "brought to my attention," she has two hours to make an initial report and then send it to the State Agency. V1 stated after she does a thorough investigation, she will send the final report with a conclusion to the state agency within five business days. V1 stated she will "talk to anyone who would know what happened", and an injury of unknown origin would include the discoloration of skin, bruises,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

(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 13	S9999		

swelling, broken skin or a resident constantly in pain. V1 stated, "I can't dismiss anything that I can't see." V1 stated she will interview the resident who had the injury, staff who were providing care, any roommates or any potential witnesses. V1 stated she comes to a conclusion after reviewing what the injured resident "self-reported" along with the staff interviews, witness statements, medical record review, and radiology reports. V1 stated she determines a root cause analysis to "find out what truly happened." V1 stated with R68's right ankle fracture, she believes R68 was injured during an "improper transfer but I cannot prove it, with no witnesses and no proof." V1 stated after R68 returned from the hospital after her surgery, she re-interviewed R68 and R68 said that "something occurred during activities of daily living (ADL) care." V1 stated she did not use a Spanish to English translator during R68's interview.

On 3/31/21 at 10:05 AM, V3 (Infection Preventionist) stated she is often called to translate for R68, whose primary language is Spanish, but R68 does speak in English as well.

On 4/1/21 at 9:01 AM, V20 (NP) stated on 2/25/21, she was notified of R68's low oxygen saturation levels by V9 (LPN), and came to assess R68. V20 stated she and V9 were both in R68's room during her assessment on 2/25/21, and R68 was saying her left ankle hurt, saying "ow, ow", and upon examination of her left ankle and R68's left ankle pain was from a recent "wheelchair transfer issue."

On 4/1/21 at 9:01 AM, V20 (Nurse Practitioner, NP) stated on 3/1/21, she assessed R68 and noted R68's right ankle was "swollen and bruising with yellow color." V20 stated she ordered for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 14	S9999		

elevation, ice and for pain management. V20 stated, "I instructed the nursing staff that if (R68's) right ankle pain, swelling or bruising increased, with no improvements, to let me know." V20 stated she did not receive any notification from the nursing staff about R68's continued pain, swelling, and bruising to the right ankle.

On 4/1/21 at 9:01 AM, V20 stated she next saw R68 on 3/18/21 when she was having continued right ankle pain, and noted that R68's right ankle was more swollen and bruised than her assessment on 3/1/21. V20 stated she reviewed R68's records for her last visit and could see that R68's pain medication usage had increased within the past week. V20 stated she ordered a stat X-ray of R68's right ankle on 3/18/21. V20 stated V4 (Licensed Practical Nurse, LPN) notified her on 3/19/21 of R68's final results of the right ankle X-ray indicating a fracture. V20 stated she contacted V27 (Attending Physician) and V20 then ordered for R68 to be transferred to the hospital for evaluation and treatment. V20 stated nursing staff should have notified her that R68 was having "more and more pain to her right ankle." V20 stated, "This should not have been neglected. I should have been notified earlier." V20 stated R68 experienced this harmful effect of pain with the nursing staff's delayed notification of having continued pain, swelling and bruising of the right ankle."

On 4/1/21 at 11:47 AM, V30 (Certified Nursing Assistant, CNA) stated R68 requires two staff to transfer from the wheelchair to the bed and he assists V37 (CNA), R68's regular CNA, with her transfers. V30 stated "a few weeks ago," he recalled an incident where R29, who was R68's roommate, stated V29 (CNA) was "not being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 15	S9999		

careful" during R68's transfer from the wheelchair to the bed, and hit R68's right ankle on the bed. V30 stated on that unknown date, he then asked R68 what happened, and R68 confirmed R29's statement. V30 stated R68's right ankle was swollen and he couldn't take her sock off because R68 said that "it hurt." V30 stated he told V9 (LPN) and V9 said he was already aware of it.

On 4/1/21 at 2:10 PM, R29 stated she was R68's roommate. R29 stated on 2/23/21, she had her room curtain closed towards R68's bed. R29 stated she heard V29 "putting (R68) in bed from her wheelchair" and then heard R68 scream "real loud" in pain. R29 stated she pulled back the room curtain and saw R68 in the bed, on her side right side leaning to the prone position, and V29 was by herself. R29 stated the next day, 2/24/21, she heard R68 tell V29 (CNA) she hurt her when she put her in bed yesterday. R29 stated V29 then apologized to R68.

Upon review of the facility's mandated reports to the state agency from July 2020 to March 2021, no facility report was noted for R68's left ankle pain from a staff transfer, with a date of 2/25/21.

Facility policy, titled "Skin Condition Assessment and Monitoring: Pressure and Non-Pressure" , dated 6/8/18, documents, in part: "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: ... Non-pressure skin conditions (bruises/contusions ...) will be assessed for healing progress and signs of complications or infection weekly ... A wound assessment will be initiated and documented in the resident chart when ... non-pressure skin

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	IL6002851	A. BUILDING: ______ B. WING ______	04/01/2021

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 16	S9999		

conditions are identified by licensed nurse ... At the earliest sign of ... other skin problems, the resident, legal representative, and attending physician will be notified. The initial observation ... will also be described in the nursing progress notes."

Facility policy, titled "Pain Management Program", dated 7/6/18, documents, in part: "Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiologically effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Guidelines: It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program ... The pain management program includes the following components: Documentation of pain assessment and monitoring ... Standards: 1. Pain assessment protocol will be initiated under any of the following situations: a. Any indication of pain ... with any condition change and/or incident associated with the potential of pain ... e. A significant increase in the use of PRN use of pain medication ... g. Resident has diagnosis that is associated with pain or discomfort ... 11. The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medication."

Facility policy, titled "Change in Condition", dated 11/29/20, documents, in part: "Purpose: To ensure that medical care problems are communicated to the attending physician or

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ELEVATE CARE IRVING PARK	4340 NORTH KEYSTONE CHICAGO, IL 60641

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S9999	Continued From page 17	S9999		

authorized designee and family/responsible party in a timely, efficient, and effective manner ... Responsibility: Licensed Nurses/Social Services. Guidelines: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: A. An accident involving a resident which results in injury or has the potential for requiring physician intervention. B. A significant change in the residents' physical, mental or psychosocial status."

Facility report, titled "Abuse Prevention and Reporting", and dated 1/22/19, documents, in part: "Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation ... Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator ... Upon learning of the report, the administrator or a designee shall initiate an incident investigation. The nursing staff is additionally responsible for reporting on a facility report the appearance of suspicious bruises, lacerations or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or the person designated to act on behalf of the administrator in the administrator's absence ... Internal Investigation: All incidents will be documented,

Illinois Department of Public Health

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S9999	Continued From page 18 whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected ... For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an 'injury of unknown source.' And injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury ... or the number of injuries observed at one particular point in time or the incidence of injuries over time. If the cause of an injury is unknown, the person gathering facts will document the injury the location and time it was observed, any treatment given and whether the physician, responsible party and/or department of public health were notified. If the injury is classified as an 'injury of unknown source,' the procedures and time frames for reporting and investigation abuse will be followed. Investigative Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether anyone has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual ... External Reporting. Initial Reporting of	S9999		

Illinois Department of Public Health

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S9999	Continued From page 19 Allegations: When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the department of public health's regional office shall be informed by telephone or fax. Public health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. The report shall include the following information: Name, age, diagnosis and mental status of the resident allegedly abused, neglected, exploited, mistreated or from whom property was misappropriated, Type of abuse reported ... Date, time, location and circumstances of the alleged incident, Any obvious injuries or complaints of injury ... All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation do not involve abuse or result in serious bodily injury; or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility ... in accordance with State law through established procedures." (A)	S9999		