FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING !L6003214 06/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6840 WEST TOUHY AVENUE ELEVATE CARE NORTH BRANCH** NILES, IL 60714 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **Initial Comments** S 000 S 000 Complaint Investigations: 2293027/ IL145928 S9999 Final Observations S9999 Statement of Licensure Violations (1 of 2): 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. 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.

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Attachment A Statement of Licensure Violations

(X6) DATE

PRINTED: 08/24/2022 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6003214 B. WING 06/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6840 WEST TOUHY AVENUE **ELEVATE CARE NORTH BRANCH** NILES, IL 60714 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 These requirements were not met as evidenced Based on interview and record review, the facility failed to safely utilize a resuscitation bag for one of three residents (R11) reviewed for respiratory care. This failure resulted in R11 sustaining a jaw dislocation after the application of the resuscitation bag. Findings include: R11 was admitted to the facility on 7/7/21 with a diagnosis of acute and chronic respiratory failure, dependence on supplemental oxygen, dysphagia, nontraumatic cerebral hemorrhage, dementia, hypertension and peripheral vascular disease. R11's progress note dated 5/2/22 at 5:10 AM documents: 0100 - oral suction, no noted distress 0330 - oral suction, no noted Distress. 0450 patient noted awake, diaphoretic, color turning pale, labored breathing. Writer took patient vitals as follows: Blood pressure - 136 / 56, Pulse - 119. Respiratory Rate - 11, Oxygen saturation - 50 percent, Temperature - 98.5 Blood Sugar - 288. 0455 - V45 (Respiratory Therapist) and V18 (nurse) initiated 100% oxygen and resuscitation bag, patient O2 saturation at 75 then. Notified MD V55(MD) via telehealth with order to Transfer patient via 911 to ED. At 0500 - called 911. 0505 patient vitals as of this time: BP - 133/78 P - 99, T 98.5, RR - 20, O2 - 97. patient awake, labored breathing. 0506 - paramedics came took over. 0510 - patient left facility, enroute to local hospital. On 6/8/22 at 910AM, V15(RT director) said if a non-respiratory patient was in respiratory distress,

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| | would perform sucti oxygen level, place mask, if still no imp | u) bag would be utilized when | | | | ## j | | |
| | On 6/9/22 at 12:42F V45(RT) when he o distress. V18 said h and did not change vital signs were non saturation was in the R11 with resuscitation oxygen concentrato V45, but unsure if of said R11 was on na | PM, V18(nurse) said he called bserved R11 in respiratory e attempted to suction R11 oxygenation. V18 said R11 mal except oxygenation e 50's. V45 started bagging on bag. V18 said R11's r was increased to the max by xygen tank was utilized. V18 sail cannula before episode of ney did not use nonrebreather | | | | | | |
| · ©. | how or what caused possible that the res have caused that if | M, V51(MD) said he is unsure R11 jaw dislocation. It is suscitation (Ambu) bag could that was the only thing that nged in R11's routine. | | · · | 72 | . 3 | | |
| | morning by staff to be her baseline oxygen | S, the patient was found this be saturating at 70% while on , she was placed on e field and then transitioned | 19. | | | | | |
| : | document: Son has has been more alter | note dated 5/5/22 at 12:18 reported that lately patient ed from baseline, unable to ne was able to do so in the om baseline. | | . 99 | · · · · · · · · · · · · · · · · · · · | 38 30. | | |

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R11's local hospital record dated 5/15/22

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6003214 06/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6840 WEST TOUHY AVENUE ELEVATE CARE NORTH BRANCH NILES, IL 60714** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 documents: Per EMS, the patient has history of hypoxia because she is unable to clear sections and has recurrent aspiration pneumonia. Today patient found to have an oxygen saturation of 72 %, so EMS was called. Patient son arrived and informed us a few days ago the patient required bagging with a BVM (resuscitation bag) and since then she has been unable to close her jaw. Mandible x-ray dated 5/16/22 documents under findings: Exam is limited due to patient positioning. No mandibular fracture is evident. On the lateral view of the right temporal mandibular joint the mandibular condyle appears positioned anteriorly relative to the mandible fossa raising concern for temporal mandibular joint dislocation although it may be related to positioning. There appears to be some mild asymmetry on the frontal view. On 5/16/22 under orthopedic injury treatment documents: Right Temporal mandibular joint. chronicity- new; range of motion-reduced: manipulation performed and unsuccessful reduction. Hospital diagnosis documents: hypoxia and closed dislocation of jaw. (No violation) Statement of Licensure Violations (2 of 2): 300.510a) Section 300.510 Administrator There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (III. Rev. Stat. 1987, ch. 111,

par. 3651 et seq.) full-time for each licensed

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING IL6003214 06/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6840 WEST TOUHY AVENUE ELEVATE CARE NORTH BRANCH NILES. IL 60714** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PRÉFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 4 S9999 facility. The licensee will report any change in administrator to the Department, within five days. This requirement was NOT MET as evidenced Based on interview and record review, the facility failed to ensure that the administrator (V1) had a valid nursing home administrator license. This has the potential to affect all 130 residents at the facility. Findings include: Facility census dated 5/19/22 documents: 130 active residents On 5/19/22 and 5/20/22, surveyor conducted a search on the Illinois Department of Financial and Professional Regulation website for V1 nursing home administrators license by name and license number with no findings. When the license number was entered independently into the system, V35's name was associated with the license number. On 5/20/22, surveyor attempted to search for V1's (Administrator) license by last name on Illinois Department of Financial and Professional Regulation with no findings for V1. On 5/20/22 at 12:45PM, V1 (Administrator) said he was unsure why his nursing home administrators license was not found on the Illinois Department of Financial and Professional Regulation, IDFPR website. V1 said he had some complications in the past with his license but thought it had been fixed. V1 said he would contact IDFPR and would have them send

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verification that he is licensed nursing home

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| | administrator to pre | sent to the surveyor. | | 1:1 | | | |
| | ⊨ Email dated 5/20/22 | 2 at 12:59PM from V34 | | | | | |
| | (directors office divi | sion of professional | 1 | 9 | | | |
| | | dministrator) documents: Per lease use this email as proof | *** | | | | |
| | that your nursing ho | ome administrator license is e assigned to V1. There is a | nt nt | | | | |
| | system error on our | end that we are working to | | <u>.</u> | | 12 | |
| | | th the license not populating in the been having a lot of issues | | | | | |
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| | issue is and how to | o you once we know what the correct it. | | | 20 | | |
| | | PM, V39 (Illinois Department | | | | | |
| 53 00 I | | fessional Regulation, IDFPR aid they were unable to locate | | | | 5 | |
| | | for V1) When asked V39 to number that was provided, | 10 | _ | | | ľ |
| à | V39 confirmed that | it did not belong to V1. V39 | | | | | |
| | | to verify anyone that worked directors office division of | | | | | |
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