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
	IL6003586	A. BUILDING: ______ B. WING ______	C 07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NORTHBROOK	270 SKOKIE HIGHWAY NORTHBROOK, IL 60062

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S 000	Initial Comments Complaint 2293941/IL147100	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting Section 300.1210 General Requirements for Nursing and Personal Care	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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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:

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.

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 Regulations were not met as evidenced by:

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Based on interviews and record reviews, the facility failed to follow fall prevention interventions to include having the bed in the lowest position while in the bed to prevent or reduce the risk of falling. This deficient practice affects one resident (R4) reviewed for fall prevention protocols. R4 rolled off the bed, and the bed was not in the lowest position. R4 sustained fractures of the medial aspect of left superior and inferior rami (pelvic) and possible fracture of the right superior pubic ramus (bones at the end of the trunk-between the spine and the legs).

Findings Include:

Reviewed facility reported incident to SA (State Agency) dated 5/15/22 and with description of occurrence that CNA reported that during routine morning rounds, CNA heard a loud thud coming from R4's room. CNA observed R4 on a landing mat, left side lying position and with complaint of left hip pain. Final report summary reads in part: R4 had an unwitnessed mechanical fall sustaining a fracture of the medial aspect of left superior and inferior rami and possible fracture of the right superior pubis ramus (pelvic fractures). Interviewed CNA and assigned nurse. R4 repositioned self to bed towards the left side of the bed with low airloss mattress causing imbalance. Resident during the time scooted to the left side of the bed and slid off the edge causing a thud that the CNA heard.

On 7/1/22 at 12:55pm, V6 (CNA) stated that V6 was assigned that day with R4. V6 stated that the last time V6 saw R4 was after V6 assisted R4 with breakfast, V6 fed R4 in bed. V6 reported that V6 left R4 in bed with head of bed slightly elevated. V6 did not position R4's bed in lowest position. V6 reported that the bed level was at the

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S9999	Continued From page 3 height above V6's knee and below V6's hip. V6 stated that it was V6's forgetfulness part that V6 did not lower the bed to the lowest position. V6 reported that V6 left R4's room to assist other residents in the unit with eating. V6 stated that he returned approximately 830am to 9am to provide R4's morning care. V6 stated that V6 went straight to R4's bathroom to put water in the basin. V6 reported that upon entering the room of R4, V6 observed R4's bed not in lowest position, R4 on his left side with wedge on R4's back. V6 reported that R4's positioned in bed was close to the edge on the left side of the bed. V6 stated that V6 did not reposition R4 at that moment because V6 was about to provide the morning care. V6 decided to go and get the water first, and that was when V6 heard a loud thud. V6 checked on R4, R4 was on the floor in left side lying position with complaints of pain. V6 reported this to the nurse on duty. On 7/5/22 at 12:45pm, V12 (RN) stated "I entered the room. In the room were V6, the roommate and R4. I observed R4 on the floor on the landing mat on the left side of the bed. R4 was on a left side lying position, kind of leaning almost. R4's legs both extended and able to move lower extremities per baseline but with pain. We assisted R4 back to bed using a mechanical lift. Pain medication was given prior to transferring back to bed. This fall incident happened approximately 830 or 900am. I observed the bed was in lowest position. V6 reported to me that V6 was about to give hygiene care to R4 and V6 pulled the wedge out, V6 then went to the bathroom to get water and left R4 in bed, no other staff present at that time. V6 heard a thud, V6 went and checked on R4, V6 then noted that R4 was on the floor on landing mat".	S9999		

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S9999	Continued From page 4 On 7/6/22 at 11: 35am, V2 (Director of Nursing) stated "Nurse reported that R4 was observed on the landing mat in a side lying position, on left side. X-ray was ordered and R4 had superior and inferior ramus fracture. I reported this incident to the state the same day when the fractures were discovered. In my investigation, what stood out during my investigation was that staff reported that earlier in the day, R4 was more alert than usual, saying "I want to go home." CNAs reported that they observed R4 at times reaching over and try to get out of bed and they redirected R4 when needed. I interviewed V6. V6 reported to me that V6 was about to do routine care to R4, was about to wash R4's face. V6 removed the wedge off R4's back to off load and V6 then proceeded to go to the bathroom to run the warm water, and according to V6 that was when R4 tried to get out of bed. V6 assumed R4 tried to get out of bed, because there is no other explanation why R4 rolled out of bed. Bed not in lowest position but in mid position, not in the highest position either. Bed does not need to be in the lowest position because R4 was not high fall risk because R4 had not fallen for over a year. R4 is dependent in bed mobility. R4 had CVA with right sided weakness. Low airloss mattress was in used. Alternating pressure of the low airloss mattress, and by R4 reaching over, it could have displaced R4's weight and caused the mattress to displaced her in bed and that night have caused R4 to rolled off the bed. In general, if a resident needs repositioning, my expectation is for my staff to provide the repositioning and/or ask for assistance if the task requires two person assist with bed mobility. It is for resident's safety and comfort also". R4's records reviewed. Fall Risk Assessment dated 4/15/22 (pre-incident) shows that R4 is at	S9999		

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S9999	Continued From page 5 risk for falls. Another Fall Risk Assessment was also completed post fall incident dated 5/15/22 and shows R4 is at risk for falls. R4's Care plan reviewed. Fall intervention with a created date of 11/18/21 reads: Provide two-person physical assistance in areas of mobility and transfer. Another fall intervention with a created date of 5/10/21 reads: Provide R4 with wedge to help with repositioning and to help prevent R4 from rolling out of bed. These two interventions were created before the unwitnessed fall on 5/15/22. MDS (Minimum Date Set), Section G dated 4/15/22 (Assessment pre-fall of 5/15/22) shows that in bed mobility, R4 was total dependent and requires a two-person assist. X-ray result dated 5/15/22 reads: Impression likely acute bilateral superior and inferior pubic rami fractures. Fall Prevention Program, with a revision date of 11/21/17 reads in part: To Assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Guidelines: use and implementation of professional standards of practice, communication with direct staff members, interventions are changed with each fall, as appropriate, preventative measure. In addition to use of Standard Fall Precautions, the following interventions maybe implemented for residents identified at risk: The resident will be checked approximately every two hours, or as	S9999		

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S9999	Continued From page 6 according to the care plan, to assure they are in safe position. The frequency of safety monitoring will be determined by the resident's risk factor and plan of care. (A)	S9999		