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 IL6003594 11/17/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2451 WEST TOUHY AVENUE ELEVATE CARE CHICAGO NORTH CHICAGO, IL 60645 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 **Initial Comments** S 000 COMPLAINT INVESTIGATION: 2282745\IL152883 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 Attachment A each resident's comprehensive resident care Statement of Licensure Violations plan. Adequate and properly supervised nursing

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI						en la
(11)		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	PLETED
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		IL6003594	B. WING			7/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		- 1
ELEVATE	E CARE CHICAGO NO	JRIH	ST TOUHY A'), IL 60645	VENUE		
(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 APPROPRIATI DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 1		S9999			
	care and personal cresident to meet the care needs of the re	care shall be provided to each e total nursing and personal esident.				
	Nursing and Person d)Pursuant to subs	General Requirements for nal Care ection (a), general nursing at a minimum, the following		=		
	and shall be practic seven-day-a-week 3) Objective observ	ed on a 24-hour,				
	emotional changes determining care re further medical eva	, as a means for analyzing and equired and the need for solution and treatment shall be aff and recorded in the				2
ż	resident's medical : These regulations v	record. were not met as evidenced by:		5 2		
				÷		
10.1	failed to correctly a failed to administer pressure ulcer wou resident (R1) who h locations on the bo- and stage 4 pressure	and record review, the facility ssess pain for a resident and pain medication before nd dressing changes, for a has pressure ulcers in tendy that are at multiple stage 3 are ulcers. This failure affected				
	pain management.	f two residents reviewed for				
y#33	Findings include:					
	with multiple pressu did not respond to g instructions. R1 wa (Minimum Data Sta	Dam, R1 was observed in bed are ulcer wound dressings. R1 greetings and could not obey s non-verbal. R1's MDS attus) dated 11/1/22, section B a persistent vegetative state.		28 28 22	×	,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		IL6003594					
					11/1	11/17/2022	
NAMEOF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
S9999	Continued From pa	age 2	S9999				
20	R1's MDS section	C dated 11/1/22, does not	1				
		r BIMS (Basic Interview for			10.		
	Mental Status).	•				17.5	
	0-44/7/00-44-55	1/0 /511/5				+1.5	
	on 11///22 at 1:55	pm, V6 (RN/Registered Nurse) mily complained about R1 not					
	getting pain medic	ation for pressure ulcers V6	1				
	getting pain medication for pressure ulcers. V6 added that he (V6) usually asks the wound nurse						
	for the time frame	for wound dressing change for					
		iven pain medication before]				
	the wound care.	27 g	1				
	On 11/16/22 at 12:	06pm, V14 (R1's family) stated					
	"On October 15th.	went to see him (R1) at the					
	nursing home and	a female nurse was changing					
	the dressing on hir	m (R1). I asked when was the		30 W(0)			
3		ot pain medicine, and the	1 1		n 2		
		e computer and said it was on r. That was how I knew that my	1				
		pain when they changed the					
	dressings."						
	7"		1			7	
	On 11/17/22 at 11:	47am, V13 (R1's Physician)	i				
		garding R1's pain during					
1	ulcers on the body	with ten different pressure V13 stated, R1 has over the					
- 1		cation (Tylenol) for mild to					
	moderate pain and	Oxycodone for severe pain.					
	and that they should	d be careful not to give too					
		medication, but we want to		7			
ļ	make sure he's cor	mfortable. V13 explained that					
		ess pain with Anoxic Brain uld be pain during dressing					
		ng and repositioning the			1	Š.	
		in medication should be given		H.S.		0)	
	about half hour bef	ore the dressing changes. The					
	surveyor informed	V13 that the records show that					
		type of pain medication for a		91	7)		
		responded "I did not know that			A)		
	uley alan't give it (D	pain medication) for days, that's			-		

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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: __ B. WING IL6003594 11/17/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2451 WEST TOUHY AVENUE ELEVATE CARE CHICAGO NORTH CHICAGO, IL 60645 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) S9999 Continued From page 3 S9999 not good. I will follow up on this." R1's Physician Order Sheets (POS), Medication Administration Records (MAR), Care Plan, and Face Sheet were reviewed and showed the following: R1's Face Sheet shows a diagnosis of Chronic Pain dated 9/20/22. R1's care plan dated 9/21/22 states that R1 has acute/chronic pain related to wounds: Intervention states "Administer Analgesia as per orders. Give half hour before treatments or care as needed. R1's care plan dated 9/21/22 with revision date 10/31/22 states that R1 has multiple pressure injuries as listed: Anterior neck, Left Achilles, left lateral Malleolus, Left Ear, Left Heel, Left Ischium, Left Lateral Foot, Left Trochanter, Right Ischium, and Sacrum. Intervention states in part "Administer medications as ordered." R1's POS dated 10/27/2022 shows an order for Oxycodone HCL tablet, 5mg (milligrams) with original start date 10/10/22; Give 1 tablet via G-Tube (Gastrostomy Tube) every 4 hours as needed for moderate for severe pain (pain scale 5-10). R1's POS dated 9/20/22 has orders for Acetaminophen 500 mg, give 1 tablet via G-Tube every 4 hours as needed for pain, do not exceed 4000mg per day. R1's MAR for 10/1/22 through 10/31/22 has no entries for the Pain Level and no Acetaminophen was given. R1's MAR for 10/1/22-10/31/22 and 11/1/22 to 11/30/22 show that R1 was scheduled to have pain level assessed/rated every 4 hours and receive Oxycodone 5mg via G-Tube according to

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATI	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED		
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		IL6003594	B. WING			C 11/17/2022	
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(YA)ID	SHMMARYSTA			500,400,00			
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	•			DEFICIENCY)			
S9999	Continued From page 4		S9999				
in .	the pain level. However, R1 did not receive the scheduled pain-rating on 10/10/22, 10/12/22, 10/14/22 through 10/18/22, 11/5/22 and 11/6/22, and no pain medication was given on those dates.						
	was interviewed reg for the multiple pres to notify the nurse to	m, V5 (Wound Care Nurse) parding pain medication for R1 sure ulcers. V5 stated, "I try p give pain medication 30 inging the dressings."					
34	was interviewed. V2 is non-verbal, we me so many stage 3 an The pain medication the clock for comfor know." V2 was aske someone with multipressure ulcers coula dressing change.	am, V2 (Director of Nursing) stated, "Because the patient ust anticipate the pain; he has d stage 4 pressure wounds. In should be scheduled round t. We will let the doctor d to describe the kind of pain pole stage 3 and stage 4 ld possibly experience during V2 stated "Stage 4 pressure the tissues and muscles and very painful."	n				
N	Coordinator-RN/Reginterviewed regardin before wound treatmedicate him (R1) 3 dressing change. (R	am, V12 (Wound Care gistered Nurse) was g R1's pain medication nent. V12 stated, "We try to minutes before wound 1) was admitted with all the m was acquired at the					
	Admission Pain Assesurveyor. This Pain I that R1 "Obeys com tremors, numbness	rse Manager) presented R1's essment dated 9/20/22 to the Evaluation shows in #1 "Met" mands, denies weakness, or tingling". This inaccurate bught to the attention of V11.					

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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: C B. WING IL6003594 11/17/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2451 WEST TOUHY AVENUE **ELEVATE CARE CHICAGO NORTH** CHICAGO, IL 60645 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S9999 Continued From page 5 S9999 V11 stated, "Oh no, the patient does not obey command and is not verbal, that is wrong. It was an agency nurse that did the pain assessment." Also, #2, #3 and #4 of the assessment were left blank and not assessed. The surveyor asked V11 how a nurse would be able to manage pain for a resident with ten pressure ulcers, who is non-verbal, and the agency nurse that did the pain assessment wrongly assessed the pain. V11 nodded and did not respond to this question. On 11/9/22 at 11:36am, V2 (Director of Nursing) presented the facility's policy on pain management. The policy dated 11/28/12 with revision date 7/6/2018 states: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Pain Management Program includes Assessment of non-verbal residents for signs and symptoms of pain. #12 states: Pain Control will be assessed during routine medication passes. The facility did not follow these guidelines. (B)