STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005904	A. BUILDING: _____ B. WING _____	C 03/28/2023

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ELEVATE CARE COUNTRY CLUB HILL	18200 SOUTH CICERO AVENUE COUNTRY CLUB HILLS, IL 60478

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S 000	Initial Comments Complaint Investigations: 2392033/IL157382 2392092/IL157473 2391752/IL157029 Investigation of Facility Reported Incident of 03-06-2023/IL157818	S 000		
S9999	Final Observations Statement of Licensure Violations 1of 4: 300.610a) 300.1010h) 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 300.1010 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	S9999	**Attachment A** Statement of **Licensure Violations**	

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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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Regulations are not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow professional standards of quality care and adequately monitor oxygen saturation levels for one resident (R10) out of three reviewed for change in respiratory status.

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S9999	Continued From page 2 This failure resulted in R10 being sent to the local hospital for hypoxic respiratory failure. Findings include: On 3/23/23 at 9:38am, V21 (nurse) stated that V21 does recall R10. V21 stated that V21 does recall that R10 would remove nasal cannula at times. V21 stated that when V21 assessed R10, the nasal cannula prongs were not completely in R10's nose. V21 stated that V21 repositioned the nasal cannula prongs further into R10's nose. V21 stated that V21 does not recall any further details on the event on 1/18/23. V21 stated that V21 charted all the details in R10's medical record. On 3/23/23 at 1:40pm, V37 NP (nurse practitioner) stated that she is unsure reason staff were not monitoring R10's respiratory status and oxygen saturation levels, but staff should be following these facilities policies. V37 stated that V37 would expect staff to be monitoring vital signs, including respirations and oxygen saturation level at least every shift. V37 stated that for residents receiving supplemental oxygenation, the nurse needs to be checking their oxygenation level. V37 stated that if a resident's oxygen saturation level drops to 82-84% on oxygen, the nurse should increase the resident's oxygen, remain with the resident to monitor status, and call EMS 911. V37 stated that with nasal cannula, can administer up to 8 liters of oxygen. If more than 8 liters is needed to get oxygen saturation level up into the 90s, the nurse should change to a non-rebreather mask. V37 stated that V37 would have expected the nurse to increase oxygen up to 8 liters and monitor R10's oxygen saturation level to see if it was improving and continue monitoring until EMS paramedics	S9999		

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S9999	Continued From page 3 arrived and took over R10's care. Review of R10's medical record, dated 1/18/23 at 6:00am, V21 (nurse) noted: V21 was called to R10's room by CNA (certified nurse aide) staff, who reported R10 unresponsive. V21 assessed R10 and noted R10 to be very lethargic during assessment and non-responsive to tactile stimuli. R10 had shallow breathing and oxygen saturation level between 82-84% at 3 liters oxygen via nasal cannula. Vital signs: blood pressure 110/50, pulse 80 beats/minute, temperature 97.2 degrees, respirations 14/minute. EMS (emergency medical services) 911 call initiated and paramedics in route. On 1/18 at 6:16am, V21 noted paramedics x 3 arrived via ambulance and stretcher. R10 remains lethargic at this time with shallow respirations. R10 being transferred to the hospital per paramedics. On 1/18/23 the nurse noted R10 was admitted with a diagnosis of cardiac arrest. There is no documentation found in R10's medical record noting any interventions (increasing amount of oxygen, continuous oxygen saturation monitoring, monitoring respiratory status) were implemented on 1/18/23 prior to EMS 911 arrival. Review of R10's hospital medical record, dated 1/18/23, notes R10 presented to the emergency room at 6:40am. EMS 911 were called for a resident unresponsiveness. Last known normal is unknown. Upon EMS arrival at R10's bedside, R10 had agonal respirations (gasping for air during a serious medical emergency). R10 initially had a heartbeat but then lost it shortly after EMS'	S9999		

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S9999	Continued From page 4	S9999		

arrival. CPR (cardiopulmonary resuscitation) was initiated, and medication administered; return of spontaneous circulation was obtained. R10 remained with no movements and no improvement in mental status. R10's pupils minimally reactive. Distant breath sounds throughout lungs. R10 with generalized edema (swelling) throughout. R10 was intubated and placed on a ventilator. By 9:28am, R10's bilateral pupils were nonreactive and remains unresponsive. R10 expired on 1/20/23 at 6:40pm, cause of death: hypoxic respiratory failure.

Review of R10's EMS run sheet, dated 1/18/23, notes the facility contacted EMS at 5:53am. EMS crew was dispatched and arrived at the facility at 5:58am. EMS crew at R10's bedside at 6:00am and found R10 unresponsive in bed. R10's respirations were 6-8 breaths/minute and shallow. R10 was quickly transferred to cot and ventilations were assisted to R10. As soon as R10 was placed in ambulance, R10 went pulseless and without any respirations. CPR was performed and ventilations continued. Return of spontaneous circulation was obtained. R10 remained unresponsive.

Review of R10's medical record notes R10 was admitted to this facility on 10/21/22 with diagnosis including hypertensive heart disease and shortness of breath.

Review of R10's medical record notes R10's respirations and oxygen saturation level were last documented on 12/7/22.

Review of R10's medical record notes V49's (attending physician) last documented face to face visit with R10 was on 11/4/2022. V37's NP (nurse practitioner) last documented face to face

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S9999	Continued From page 5 visit with R10 was on 11/3/2022. Review of R10's chest x-ray, dated 1/5/23, notes x-ray results were reported on 1/5 at 11:48pm. Results show infiltrates in both lung bases. This report was reviewed by V50 RN (registered nurse) on 1/10/23 at 1:15pm. Review of R10's POS (physician order sheet), dated 10/24/22, oxygen at 2 liters per nasal cannula continuous. On 11/23/22, notes an order for vital signs every shift x 14 days then daily. On 1/5/23, notes an order for chest x-ray diagnosis shortness of breath. On 1/10/23, orders for doxycycline (antibiotic) and Augmentin (antibiotic) oral twice daily times 10 days for pneumonia. There is no documentation in R10's medical record noting reason antibiotics were not started until 1/10/23 when chest x-ray results were reported on 1/5/23. Review of R10's admission physician note, dated 10/22/22, notes R10 presented to the outside hospital after an unwitnessed fall in the bathroom where R10 landed on both knees. During hospital stay, R10 underwent surgery to both femurs. R10's hospital course was complicated by hypoxia requiring BIPAP and CPAP (both are non-invasive ventilation therapies to treat respiratory distress). R10 was medically stabilized however not yet at her functional baseline and was admitted to this facility on 10/22/2022 for course of subacute rehabilitation. Per V1 (administrator) this facility does not have an oxygen saturation level monitoring policy or an oxygen administration policy. (A)	S9999		

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S9999	Continued From page 6 Statement of Licensure Violations 2 of 4: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)5) 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 300.1010 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	S9999		

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S9999	Continued From page 7 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on interviews and record reviews, this facility failed to follow their pressure sore prevention protocols for a resident assessed to	S9999		

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S9999	Continued From page 8 be at moderate risk for skin breakdown. This affected 1 of 3 residents reviewed for pressure sore prevention. This failure resulted in R2 developing an unstageable pressure wound 10 days after admission. Findings include: R2 was admitted in the facility with no skin issue, documented on 12/2/22 as skin intact. R2's Braden scale (Identifies patients at risk for pressure ulcers) score is 13 (Moderate Risk for skin alteration). R2 developed a pressure injury on R2's sacral area documented first on 12/12/22. The facility wound care team seen R2 on 12/13/22, seen by facility wound care nurse. Wound care team noted on 12/13/22 facility-acquired pressure ulceration epithelial or red=20%, slough white fibrous=80%, 5cm (L) x 5 cm (W) x unknown (D). R2 was seen by the Wound Nurse Practitioner on 12/15/22. Initial evaluation reveals unstageable pressure injury on sacrum. There is minimal to moderate amount of serous exudate. Significant contributors include generalized muscle weakness, impaired mobility, and inevitable effects of aging. Initial wound encounter measurements are 5cm x 5cm x 0.1 (L x W x D) treatment was medi-honey and cover with dry dressing change daily and as needed. V2 (DON) documented on 12/12/22, reads in part: Family thanked writer at end of conversation. NP notified of resident's new skin condition, new order received for Tylenol 1000mg q/every 6 hours as needed for pain, low air loss mattress, and ensure to be added to diet due to poor appetite. New orders noted and carried out.	S9999		

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S9999	Continued From page 9 Surveyor interview of V2 on 3/22/23, V2 stated that she informed the wound care team at the facility. V2 did not see the wound of R2 and the only orders that was put in place were the three mentioned in her documentation on 12/12/22. V2 does not recall entering any wound treatment order but remembers informing the wound care team of the new skin condition. On 3/14/23 at 1:15pm, V3 (Wound Treatment Nurse) stated "R2 skin intact upon admission 12/1/22 and on 12/12/22 identified by the nurse. On 12/13/22 was seen by me (wound nurse). One site, sacrum, unstageable. Measurement 5cm x 5cm, and the depth was unknown. There is a necrotic tissue covering the wound and the depth cannot be determine". Facility provided R2's TAR (Treatment Administration Record) for December 2022 reviewed. Order with a start date of 12/15/22 and discontinued date of 12/16/22, Sacrum: medihoney every day shift every Tuesday, Thursday and Saturday, cleanse with NSS (Normal Saline Solution), pat dry, apply medi honey to sacrum, zinc oxide barrier cream to periwound, cover with dry dressing and this is the first documented treatment for R2's sacral wound, then on 12/17/22, the second documented treatment for R2. No treatment on 12/12/22 when it was initially observed, none on 12/13/22 when the wound care team seen the wound, and none on 12/16/22. There was an order for as needed wound treatment order for sacral, but no signature noted in TAR that as needed order was rendered at all. Facility Policy for Pressure Injury and Skin Assessment with a revision date of 1/17/18, reads	S9999		

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S9999	Continued From page 10 in part: Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to charge nurse who will perform the detailed assessment. Physician ordered treatment shall be initiated by the staff on the electronic Treatment Administration Record (TAR) after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses noted. (B) Statement of Licensure Violations 3 of 4: 300.610a) 300.1210b) 300.1210d)6) 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.	S9999		

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S9999	Continued From page 11 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. These Regulations are not met as evidenced by: Based on interviews and records reviewed, the facility failed to ensure safety while providing direct resident care. The facility also failed to monitor one resident with history of dysphagia and required one person feeding assistance who was eating ice cream in the hallway to prevent an avoidable fall incident. This affected 2 of 3 (R10, R11) reviewed for safety and avoidable accidents. This failure resulted in R10 rolling out of bed during care and sustaining a left oblique distal femur fracture and a right mildly comminuted oblique distal femur fracture with minimal	S9999		

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displacement. R11 fell out of her wheelchair attempting to pick up ice cream cup, sustaining a wrist fracture.

Findings include:

On 3/22/23 at 11:00am, V2 DON (director of nursing) stated that R10 informed V2 that R10 had a fall while receiving ADL care. V2 stated that V2 had just started working at this facility in September 2022 and was just getting adjusted to facility at the time of R10's fall incident on 10/30/22. When asked to review staff interviews for further details of the incident, V2 stated that V2 did not keep any documented interviews she may have conducted related to R10's fall event while receiving ADL care. V2 acknowledged that any staff interviews V2 may have done should be kept with the fall event. V2 stated that R10 was confused. V2 stated that this facility does not have a post falls policy. V2 stated that there is only a fall prevention policy.

On 3/22/23 at 2:25pm, V33 (restorative nurse) stated that V2 DON is responsible for conducting staff interviews to obtain details of each resident fall. V33 stated that the fall protocol is to put immediate interventions in place for the resident then discuss the fall event in IDT (interdisciplinary team) meeting and determine what changes need to put in place to prevent further falls. V33 stated that V33 does not recall R10 or R10's fall on 10/30/22. V33 stated that the nurse should document a fall risk assessment after each fall. V33 stated that if the resident fall occurs when V33 is not present in facility, the nurse is expected to put interventions in place immediately as well as document the event and interventions implemented in the resident's medical record. V33 stated that R10's recent fall

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with fractures prior to admission to this facility is documented in the fall risk assessment as a history of falls.

Review of R10's BIMS (brief interview of mental status) score, dated 10/28/22, notes R10's score was 14 out of 15.

Review of R10's MDS (minimum data set), dated 10/28/22 and 1/18/23, notes R10 requires extensive assistance of two staff members with bed mobility.

Review of V35's (physician) note, dated 11/1/22, notes R10 had a fall on 10/30/22 per chart, primary physician has ordered x-rays of lumbar spine, right arm, bilateral hips/pelvis, x-rays being taken at the bedside this morning. Pain regimen includes acetaminophen 1000mg (milligrams) twice daily and tramadol (pain medication) as needed. R10 reports pain in bilateral knees, mostly where incisions are located on the anterior and lateral aspects. R10 reports pain is constant and moderate, non-radiating, aching quality and improves somewhat with Acetaminophen/tylenol.

On 11/2/22 at 3:12pm, V36 LPN (licensed practical nurse) noted: R10 verbalized that R10 had a fall on 10/30/22 while receiving care with her ADL'S. R10 is now complaining of pain to the right side of her body. Physician was called and left a message in regard to having an x-ray or her right arm and hip.

On 11/2/22 at 3:23pm, V36 LPN noted V37 NP (nurse practitioner) gave orders to have an x-ray of bilateral hips and pelvis as well as the right arm.

On 11/3/22, V5 ADON (assistant director of

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nursing) noted order received to include lumbar spine x-ray due to R10's complaint of back pain per V37 NP at this time. Order placed, awaiting outside diagnostic imaging company arrival.

11/3/22, V37 NP, R10 seen today due to recent fall, per R10 she rolled out of bed, denies hitting her head, no bruising/hematoma noted on the head, R10 oriented x 3. Slight bruising noted to left neck most likely secondary to nasal cannula pulling when R10 fell. Staff to monitor for changes in mentation, activity intolerance, complains of pain. Maintain facilities fall prevention strategies, follow facilities post fall policy including neurological checks. Monitor neck bruising.

There are, no post fall head to toe body assessment or post fall risk assessment documented in R10's medical record after fall on 10/30/22.

Review of R10's medical record notes R10 was admitted to this facility on 10/21/22 with diagnoses including right femur fracture, left femur fracture, and history of falling.

Review of R10's admission fall risk assessment, dated 10/21/22, notes regarding the history of falling, it is documented 'no'.

Review of R10's fall risk assessment, dated 11/23/22, notes regarding the history of falling, it is documented 'no'.

Review of R10's fall incident report, dated 11/2/22 at 3:03pm, notes R10 verbalized that R10 had a fall on Sunday, 10/30/22, while receiving care with her ADLs. There is no post fall assessment by the interdisciplinary team to determine root cause of

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S9999	Continued From page 15 fall to prevent further falls from occurring. Review of R10's admission note, dated 10/22/22, the physician noted R10 presented to the outside hospital after an unwitnessed fall in the bathroom where R10 landed on both knees. Bilateral knee x-rays revealed a left oblique distal femur fracture and a right mildly comminuted oblique distal femur fracture with minimal displacement. Orthopedic surgery consulted, R10 underwent surgery to both femurs. R10 was medically stabilized however not yet at her functional baseline and was admitted to this facility on 10/22/2022 for course of subacute rehabilitation. R11 was admitted to the facility in 5/27/21 with a diagnosis of alzheimer's disease, dysphagia, dementia hypertension, history of falling, and venous insufficiency. R11's brief interview for mental status dated 2/22/23 documents a score of 3/15 which indicates severe cognitive impairment. Section G under eating documents: 3-Extensive assistance- resident involved in the activity, staff provide weight bearing support and one-person physical assist. R11's dietary slip documents: Aspiration precautions and feeding assistance. On 3/22/23 at 1:13PM, V28 (MDS) stated for minimum data set for eating with a score of 3-extensive assistance and a score of 2-one-person physical assist indicates that resident is being feed by staff. On 3/23/23 at 12:55pm, V20 (speech) stated R11 needs one to one feeding due to dementia, she may not know how to use a spoon or pick up a cup.	S9999		

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S9999	Continued From page 16 On 3/22/23 at 3:25pm, V31 (Nurse) stated she observed R11 near the elevator. V31 stated she was on the other side of the nursing station at her medication cart. V31 stated she saw R11 leaning forward and fell out of her chair. R11 was eating ice cream prior to the fall and the ice cream was on the floor and it appeared that R11 was trying to reach the ice cream cup on the floor causing her to fall. R11 complained of pain to her right wrist. On 3/22/23 at 2:16pm, V33 (restorative nurse) stated staff should be monitoring R11 while she is eating in case, she needs assistance or monitoring because she has dysphasia and is at risk for choking. V33 stated the fall on 3/6/23 occurred when R11 was sitting in her wheelchair and fell forward trying to pick up something possibly the ice cream off the floor. V33 stated R11 has no history of falls. R11's facility incident report dated 3/6/23 under description: Resident stated she wasn't sure how she fell. Witness statements: V31(Nurse) dated 3/6/23 documents: writer witnessed the resident fall from her wheelchair onto the floor. Prior to the fall R11 was sitting in her wheelchair eating ice cream. R11 lost her balance and fell forward out of her wheelchair, The resident landed on her right side and stated she had pain to her right wrist, R11 facility final reportable dated 3/9/23 documents: On 3/6/23 at approximately 3:50PM, resident observed by staff sitting in her wheelchair near the nurse's station, eating ice cream from a cup. At approximately 3:55PM, staff observed resident lean forward as if she was attempting to pick something up off the floor. R11 was then observed falling out of her wheelchair on her right side. Ice cream cup noted near	S9999		

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S9999	Continued From page 17 resident's foot. R11's radiology results dated 3/6/23 documents: under right hand x-ray impression acute hairline distal radial intra-articular fracture. R11's care plan revised on 6/2/22 documents: R11 has difficulty swallowing and has the potential for choking, aspiration and other adverse events. Interventions revised 11/4/21 documents: Speech therapy recommends diet texture to mechanical soft/thin liquids given close supervision for cues to use general aspiration/reflux precautions. R11's care plan revised on 2/2/23 documents R11 had a functional deficient in her self-performance for eating related to cognitive impairment due to dementia. She requires supervision with verbal cues. Intervention cue/assist R11 to spear food with fork/scoop food with spoon. (A) Statement of Licensure Violations 4 of 4: 300.610a) 300.1010h) 300.1210a) 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	S9999		

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S9999	Continued From page 18 the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) These Regulations are not met as evidenced by:	S9999		

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S9999	Continued From page 19 Based on interviews and records reviewed, the facility failed to accurately assess residents impaired nutritional status, implement, monitor, and evaluate the effectiveness of interventions for two residents (R3 and R4) reviewed for nutrition and hydration in a sample of 7. These failures resulted in R4 experiencing a mental change in condition and taken the local hospital. R4 was diagnosed and treated for dehydration, critically high potassium level, and acute kidney failure. R3 experienced an unplanned weight loss over a 30-day period without any interventions. Findings include: On 3/17/23 at 11:00am, V2 DON stated that V11 RD (registered dietitian) looks at all residents. V2 stated that the interdisciplinary team meets with V11 weekly to discuss residents. V2 stated that V2 is unsure if R4 was discussed at any of these meetings. V2 stated that recommendations made by V11 are discussed with V2, V8 ADON (assistant director of nursing), dietary manager, and restorative nurse and put in place. V2 stated that all residents are weighed monthly unless V11 recommends weekly monitoring. V2 stated that the staff are expected to document the percentage of each meal a resident consumes. V2 stated that the CNAs are expected to notify the nurse when a resident has poor intake or refuses meal. V2 stated that the nurse is expected to notify the physician and the resident's family when a resident does not eat a meal. When questioned how information is conveyed to nurses/CNAs when there is a recommendation to monitor oral intake. V2 stated that there is no order entered in the resident's medical record; CNAs are expected to document each meal.	S9999		

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On 3/14/23 at 2:50pm, V4 (restorative aide) stated that R4 refused breakfast and lunch on 3/11/23 and refused breakfast on 3/12/23. V4 stated that R4 also refused to eat on 3/9/23. V4 stated that R4 did not receive a lunch meal because R4 was transported to the hospital. V4 stated that V4 usually can get R4 to eat sweets and drink coffee, but R4 refused. V4 stated that the rule is to let the nurse know if a resident is not eating.

On 3/17/23 at 12:15pm, V4 stated that she took R4's weight on 3/12/23 but did not enter the result in R4's medical record. V4 stated that V4 did not enter R4's weight because R4 went out to the hospital the same day. V4 stated that she is not supposed to enter a weight if the resident goes to the hospital because the resident will be re-weighed upon re-admission. V4 stated that if a resident has a 5-pound weight change, the resident is re-weighed the following day or two. V4 stated that V4 always weighs R4 on wheelchair scale. V4 stated that on 3/12/23 R4's weight was 99.4 pounds. V4 stated that R4's weight was 102.7 pounds on 2/4/23. V4 stated that V4 knew R4 was not eating or drinking and knew R4's weight was off.

On 3/16/23 at 12:35pm, V10 CNA (certified nurse aide) stated that V10 was assigned to provide care for R4 on 3/10/23 from 7:00am-3:00pm. V10 stated that R4 did not have an appetite on 3/10/23. V10 stated that R4 usually eats at least 25% of meal offered. V10 stated that R4 loves coffee. V10 stated that on 3/10/23, R4 informed V10 that she was tired and did not want to eat. V10 stated that V10 was able to get R4 to eat a couple of bites, R4 refused coffee.

On 3/16/23 at 12:47pm, V12 CNA stated that on

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3/10/23 R4 ate less than 50% of her dinner. When asked to clarify the discrepancy between what V12 charted and what V12 is stating about the amount R4 ate on 3/10/23, V12 stated that R4 ate less than 50% of dinner. V12 stated that R4 usually goes to the dining room to eat but on that day R4 did not want to get out of bed. V12 stated that R4 was very tired. V12 documented on 3/10/23 R4 ate 75% of dinner meal.

On 3/17/23 at 11:53am, V11 RD (registered dietitian) stated that once monthly weights are done, V11 runs a monthly report and a weight changes report. V11 stated that V11 runs a weekly weight change report. V11 stated that V11 cannot remember if R4 was discussed during weekly interdisciplinary meetings. V11 stated that when she goes to the nursing units, she will ask the nurse if there are any changes. V11 stated that unless staff report any changes to V11, V11 will not know if a resident is not eating. V11 stated that only if a weight change is triggered in the report, V11 will review the amount eaten, interview staff for any changes, and complete an assessment and evaluation. V11 stated that R4's weight for March was not documented in R4's medical record. V11 stated that V11 was unable to review R4's weight and R4's weight loss would not be triggered on weekly weight change report.

Review of R4's hospital medical record, dated 3/12/23, notes on previous emergency room visits, R4 had been able to state her name intermittently, answer questions, and answer some basic commands which appears to be changed in today's presentation. R4's initial vital signs taken at 12:47pm: heart rate 109 beats/minute, respirations 18/minute, and blood pressure 174/87. Physical examination noted R4 awake, not oriented, moaning, and not following

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S9999	Continued From page 22 commands. R4's mucous membranes dry. R4 with increased skin turgor. Potassium critically high at 6.3 (normal range 3.4-5.1), BUN (blood urea nitrogen) level 121 (normal range 6-20), creatinine 11.41 (normal range 0.51-0.95), GFR (glomerular filtration rate 3 (normal is greater than or equal to 60). Diagnoses: acute kidney failure-prerenal azotemia, elevated potassium level, dehydration, altered mental status. Admitting physician's assessment on 3/12/23 notes: R4 is ill-appearing, obtunded (diminished responsiveness to stimuli), cachectic (physical wasting with loss of weight and muscle mass), diffuse muscle wasting of all extremities, including temples, and dry mucous membranes. R4's baseline creatinine level around 1.3. Review of V11's RD (registered dietitian) note, dated 1/30/23, notes R4's estimated needs is 1543-1764 kilocalories, 44-53 grams of protein. R4's appetite is variable per meal records. R4 remains at high nutrition risk. Continue to monitor weight trends, laboratory test results, skin, and oral intake. Review of R4's dietary profile, dated 3/2/23, notes R4's BMI (body mass index) is 19 (R4 is underweight). R4's appetite is fair. R4 has chewing difficulties. Additional risk factors include BMI 20.9 or less. It also notes to monitor weights, skin, laboratory test results, and oral intake. Review of R4's weights notes: 3/12/23, weight was 99.4 pounds. 3.2% weight loss in one month. On 2/4/23, weight was 102.7 pounds On 1/1/23, weight was 103.9 pounds On 12/7/22, weight was 103.2 pounds On 11/2/22, weight was 104.9 pounds	S9999		

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S9999	Continued From page 23 Review of R4's care plan, revised 12/19/22, notes R4 is at risk for continued weight loss related to poor appetite. Interventions include notify dietitian if oral consumption is poor more than 48 hours, administer medications as ordered, and provide nutritional supplements as ordered. Review of the amount R4 consumed at each meal for the past three months notes: January 2023, out of 93 opportunities for meals, staff documented 53 meals consumed. On 1/25/23, documentation notes R4 refused meal. February 2023, out of 84 opportunities for meals, staff documented 43 meals consumed. March 2023, out of 36 opportunities for meals, staff documented 11 meals consumed. On 3/11/23, documentation notes R4 refused breakfast and lunch. Review of the National Library of Medicine article dated 8/10/2022, notes azotemia is a biochemical abnormality, defined as elevation, or buildup of, nitrogenous products BUN, creatinine in the blood, and other secondary waste products within the body. Raising the level of nitrogenous waste is attributed to the inability of the renal system to filter (decreased glomerular filtration rate-GFR) such as waste products adequately. It is a typical feature of acute kidney injury. Prerenal azotemia is a subtype of azotemia. Acute kidney injury is generally diagnosed by an increase in creatinine by 0.3 mg/dL, creatinine increase greater than 1.5%. This diagnosis is made with urinalysis, urine electrolytes, metabolic panel and a renal ultrasound. Prerenal azotemia manifests from some insult/injury source before the kidney. Most commonly, we see this in the form of hypoperfusion, or decreased blood flow, to the kidneys from various etiologies of volume	S9999		

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S9999	Continued From page 24 depletion, such as dehydration. Review of R3's POS (physician order sheet) notes an order, dated 2/22/23, enteral feedings at 65ml (milliliters)/hour x 12 hours, start at 8:00pm and stop at 8:00am. On 2/1/23, notes orders for dialysis every Monday, Wednesday, and Friday. There is an order for pre- and post- dialysis weights per dialysis center. There also is an order for a liberalized renal diet puree, nectar thick liquids. Review of R3's weight documentation notes: On 3/10/23, R3 weighed 179.8 pounds post dialysis. R3 had a 7.2% weight loss in one month. On 2/10/23, R3 weighed 193.8 pounds post dialysis. On 2/01/23, R3 weighed 190.5 pounds. On 1/10/23, R3 weighed 190.5 pounds. On 1/09/23, R3 weighed 188.7 pounds. There is no documentation found in R3's medical record noting weights were obtained per physician orders. There is no documentation found noting R3 was re-weighed to verify weights. Review of R3's meal consumption, dated 2/13/23-3/12/23, notes there were 84 opportunities for meals. There is documentation of 26 meals consumed by R3. Of these 26 meals, R3 refused meals on three occasions and was not available for two meals. Review of R3's nutrition care plan notes R3 is at risk for malnutrition and dehydration, weights per facility protocol. Review of V11's RD (registered dietitian) note, dated 2/18/23, notes enteral tube feeding provides 65% of estimated nutrition needs.	S9999		

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ELEVATE CARE COUNTRY CLUB HILL	18200 SOUTH CICERO AVENUE COUNTRY CLUB HILLS, IL 60478

(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 25 Recent hospitalization 1/23-1/31/23. Weight loss noted post hospitalizations. Continues on, dialysis treatment 3/week. Plan: continue with current diet plan of care. Diet appropriate. There is no documentation noting V11 RD was notified of weight loss in one month. There is no documentation noting R3 was hospitalized since January 2023 to explain weight loss. Review of this facility's weight assessment and intervention policy, dated 2020, notes weights are monitored monthly or more often to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight loss. Nursing staff will record the resident weight the day they move in, the next day, and once a week for 4 weeks to establish a base weight and stability of weights. Weights shall be recorded in the resident's health record. Interventions for undesirable weight loss shall be based on the nutrition and hydration needs of the resident and the use of supplementation. Review of this facility's hydration monitoring policy, dated 2020, notes residents at risk for dehydration will be identified using the dehydration risk assessment and nutritional screening assessment. Fluids consumed at meals will be documented in addition to meal intake. The nutritional assessment shall reflect factors that put the resident at risk for dehydration as well as interventions to reduce risk factors and ensure adequate fluid intake. (A)	S9999		