Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		IL6006191	B. WING	C 12/15/2023	
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	
ELEVATE	CARE NILES		EST GOLF ROAD IL 60714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
S 000	Initial Comments		S 000		
	Complaint Survey: 2	23910421/IL167802			
S9999	Final Observations		S9999		
	Statement of Licens	sure Violations			
	300.610a) 300.1210b) 300.1210d)5 300.3240a)				
	Section 300.610 Re	esident Care Policies			
	procedures governing facility. The written be formulated by a land Committee consisting administrator, the admedical advisory conformation of nursing and other policies shall complime written policies the facility and shall by this committee, conformation and dated minutes of the solution of the policies.	dvisory physician or the symmittee, and representatives or services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed of the meeting. General Requirements for			
	and services to atta practicable physical well-being of the res each resident's com plan. Adequate and care and personal of	provide the necessary care in or maintain the highest , mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each a total nursing and personal		Attachment / Statement of Licensure	A Violations

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

TITLE

(X6) DATE

1NRN11

Illinois Department of Public Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
				С	
		IL6006191	B. WNG		12/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
ELEVATE	CARE NILES		EST GOLF ROAD		
	OFFICE THE STATE OF THE STATE O	NILES,	IL 60714		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETE
S9999	Continued From page 1		S9999		
	care needs of the res	ident.			
	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 ba				
	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 ba	asis so that a resident who			
		hout pressure sores does not			
		res unless the individual's nonstrates that the pressure	1000		
		ble. A resident having			
		receive treatment and	- 1		
	services to promote h	nealing, prevent infection,			
	and prevent new pres	ssure sores from developing.			
	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)				
	resident. (Section 2-	107 of the Act)			
	These Requirements by:	were not met as evidenced			
	Based on observation	ns, interviews, and record			
	reviews, the facility failed to consistently monitor		4		
	resident's skin every s	shift, turn and reposition			
		y out wound treatment			
	orders as prescribed, relieving interventions	and implement pressure			
		cer from recurring for one			
		d one of three residents (R3)			
	reviewed for pressure	e sore prevention. This			
AT 1 4 1 1		s sacral/right buttock stage			
	3 pressure ulcer re-optreatment orders to be	pening and new wound e obtained			

Illinois Department of Public Health

1NRN11

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WNG IL6006191 12/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8333 WEST GOLF ROAD **ELEVATE CARE NILES** NILES, IL 60714 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 Findings include: On 12/13/23 at 10:40am, this surveyor observed V12 CNA (certified nurse aide) perform incontinence care for R3. R3 was observed to have a small blue brief tucked within large yellow brief. There was a disposable incontinence pad also under R3. V12 removed the briefs, provided care, and placed two new briefs on R3. Barrier cream was not applied to R3. On 12/13/23 at 11:00am, this surveyor observed V3 (wound care nurse) perform wound care treatments for R3. R3's sacrum to right buttock stage 3 pressure ulcer was cleaned with normal saline, then medihoney, adaptic, and calcium alginate were applied to wound and covered with a bordered gauze dressing. On 12/13/23 at 12:43pm, V3 stated that R3' sacrum to right buttock wound opened again. V3 stated that V3 observed wound open during wound treatment today. V3 stated that he will notify the physician that wound has re-opened and obtain treatment orders. V3 stated that there should be a single flat sheet and one brief when a resident is on a low air loss mattress. V3 stated that a disposable incontinence pad and double briefing resident is not recommended. V3 stated that the low air loss mattress manufacturer's instructions recommend only a flat sheet under resident. V3 stated that he was not aware that

Illinois Department of Public Health

V10 (wound care physician) changed R3's treatment order for R3's sacrum/right buttock wound on 12/6/23. V3 acknowledged R3's sacrum/right buttock treatment should have been changed on 12/6 per V10's order. V3 stated that low air loss mattress are designed to allow air flow to pass through and prevent moisture build

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		TION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	IL6006191		B. WNG	C 12/15/2023	
	PROVIDER OR SUPPLIER	8333 WI	ADDRESS, CITY, STATE /EST GOLF ROAD IL 60714	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
S9999	up. On 12/13/23 at 2:00p performing wound ca wound measures 2.5 the wound is superfice. On 12/13/23 at 3:15p physician) stated that have been placing two when providing care, incontinence briefs of and should not be us no literature in medicincontinence pad wordevelopment or detectommon sense not to incontinence pad und mattress. V10 stated (wound care nurse) a orders for R3's sacruit. On 12/13/23 at 3:35p when the order is write (electronic medical rethe resident's TAR (trrecord). V11 stated that if a transhift, evening shift, at to pop up until it is minurse on that shift. Vare completed every stated that if the scheduled treatments completed.	pm, V3 was observed are treatment for R3. R3's 5cm x 1cm. V3 stated that cial, shallow open wound. pm, V10 (wound care at V10 was not aware staff two incontinence briefs on R3 to V10 stated that using two could affect wound healing sed. V10 stated that there is cal journals on what effect the could have on wound the purchase of the	S9999	60714 ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)	

1NRN11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
IL6006191		B. WNG		С	
		10006191	D. 11110		12/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
ELEVATE	CARE NILES	8333 WE NILES, I	ST GOLF ROAD L 60714		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S9999	Continued From page 4		S9999		
	pressure ulcer, right bulcer, chronic respirat	ted to, left buttock stage 4 puttock stage 3 pressure ory failure, tracheostomy, functional quadriplegia, xic brain damage.			
		data set), dated 11/2/23, y impaired cognition and staff for all ADLs.			
	R3's braden score, da is at very high risk for	ated 12/8/23, notes resident skin breakdown.			
	protector at all times of	der for a low air loss order, dated 11/15, for heel or offload with pillows. On ry shift. On 12/11, turn and			
	has an ADL self-care to activity intolerance, cognition. R3 is totally	evised 10/21/22, notes R3 performance deficit related impaired mobility, and poor y dependent and requires ssistance with bed mobility.			
	development related to bladder/bowel inconting 10/21/23, R3's sacrum pressure ulcer re-oper identified, but not limit barrier ointment after a heel protectors at all ti	nence, co-morbidities. On in to right buttock stage 3 ned. Interventions ed to, apply moisture each incontinent episode, imes or offload with pillows, and turn and reposition			
		sician) note, dated 12/6/23, eletal functional status is and lower			

Illinois Department of Public Health

FORM APPROVED Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6006191 12/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8333 WEST GOLF ROAD **ELEVATE CARE NILES NILES, IL 60714** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 5 extremities-contractures stiff. Sacrum to right buttock stage 3 pressure ulcer, re-opened on 10/21/23. Wound measures 2.5cm (centimeters) x 5cm, 50% epithelialization and 50% maroon. Treatment changed on 12/6 to clean with normal saline, apply zinc oxide, and cover with bordered gauze. R3's TAR (treatment administration record), dated December 2023, notes R3's skin was not checked on the evening shift or night shift on 12/10, the evening shift on 12/11, or the evening shift on 12/12. It also notes R3 was not turned or repositioned from 12:00pm until midnight on 12/12 or 8:00am and 10:00am on 12/13. The low air loss mattress manufacturer's instructions note the low air loss mattress is designed to prevent and treat pressure ulcers. Residents can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the resident. (B)

Illinois Department of Public Health