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	IL6006191	A. BUILDING: _____ B. WING _____	R 12/07/2023

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ELEVATE CARE NILES	8333 WEST GOLF ROAD NILES, IL 60714

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{S 000}	Initial Comments Revisit to Annual Licensure Certification Survey & Complaint Survey of 7/21/2023, Revisit to Complaint Survey exit 10/19/2023 & Revisit to Complaint Survey exit 6/15/2023	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)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 300.1210 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	{S9999}	**Attachment A** Statement of Licensure Violations	

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{S9999}	Continued From page 1 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. 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: 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 Requirements were not met as evidenced by: Based on interview and record review, the facility failed to implement effective preventive measures according to a resident plan of care and ensure a pressure relief mattress is operated correctly and in proper working order while in daily use, to prevent a new pressure ulcer for two residents (R1, R2) who were at risk for developing a pressure ulcer. As a result of the failure R1 developed an unstageable pressure ulcer to his left buttock area and R2 obtained an unstageable pressure	{S9999}		

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{S9999}	Continued From page 2 injury to her sacral region. Findings include: Reviewed wound report from 09/01/2023 through 12/04/2023 provided by facility that indicated both R1 and R2 had active facility-acquired pressure injuries that were both identified on 11/29/2023. 1. R1's face sheet indicated resident admitted o facility on 05/10/2023 and has a past medical history not limited to: multiple sclerosis, acute embolism and thrombosis of deep veins, morbid obesity, chronic kidney disease stage 4, personal history of malignant neoplasm of large intestine and large intestine, presence of colostomy and urostomy, and unstageable pressure ulcer. R1's quarterly Minimum Data Set (MDS) Section C dated 10/23/2023 indicated resident scored 13/15 on his Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. Section M dated 10/23/2023 indicted R1 is at risk of developing pressure ulcers/injuries, currently receives pressure ulcer/injury care to his unstageable pressure ulcer/injury, has a pressure reducing device for bed/chair, but is not on a turning program. R1's active physician orders read in part: heel protector or offload with pillows; low air loss mattress at all times; sacrum/buttocks/perineum: cleanse with normal saline, apply zinc oxide cream or vitamin A/D ointment twice daily and as needed (11/15/2023). No active order found for a turn/reposition program. R1's care plan with date initiated of 05/11/2023 reads in part: presents with a functional deficit in bed mobility related to generalized weakness and neurological disorder; admitted with skin	{S9999}		

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{S9999}	Continued From page 3 alterations (right heel, right medial leg, left thigh moisture-associated skin damage [MASD]) and is at risk for skin break down related to diagnosis of multiple sclerosis, hypertension, chronic kidney disease, obesity, seizures, depression and anxiety; 11/15/23 Readmitted with sacrum/buttocks/perineum-MASD; 11/29/23 left buttock extending to right buttock-unstageable, revision on 11/29/2023. Interventions: low air loss mattress (revision on: 12/03/2023), may turn and reposition every two hours and as needed (date initiated: 05/11/2023). R1's wound assessment report completed by V4 (Wound Care Nurse/LPN) dated 11/29/2023 indicated the following: Braden Score: 13 (Moderate Risk); facility-acquired unstageable pressure wound to left buttock extending to right buttock with assessment date of 11/29/2023 5:08 PM that measured 9.00 centimeters x 11.00 centimeters x 0.10 centimeters (length x width x depth). Tissue type: Intact Skin=20%, Bright Pink or Red=20%, Slough White Fibrinous=30%, Necrotic Soft, Adherent=30%, Under current plan and comments section, the following is indicated: sudden worsening of moisture-associated skin damage (MASD) wound due to the malfunction of resident's low air loss (LAL) mattress. On 12/04/2023 at 12:17 PM observed R1 lying in bed on his back with his upper body and both knees partially turned onto resident's left side and facing towards the wall/room door. Noted low-air loss mattress in place set to 270 pounds (lbs.) that was covered with a flat sheet which was visibly wrinkled underneath the resident. Noted a small pillow partially beneath R1's left shoulder, a flattened pillow placed next to R1's backside that was partially underneath R1's lower back, and heel protectors were in place to bilateral lower	{S9999}		

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{S9999}	Continued From page 4 extremities. R1 said he has several wounds, then said the one on his buttocks was obtained while at the facility. R1 added that he has no issues with daily wound care but said that he doesn't get physically turned/repositioned in bed by the nursing staff. R1 then said he is only able to reposition his upper body with the use of his half rails but is unable to reposition himself entirely onto his right side. R1 then said the last time staff turned and/or repositioned him was "around 02:00 AM". On 12/05/2023 at 10:53 AM observed R1 lying in bed on his back partially turned onto his left side with his upper body and both knees facing towards the wall/room door. R1 said he received wound care this morning then stated that "starting yesterday, they started coming in and turning me more often". R1 added that before previous day, he would "mostly stay in the same position" which is on his left side facing the door. Noted low-air loss mattress remains in place that was covered with a flat sheet which was visibly wrinkled underneath the resident. On 12/05/2023 at 11:06 AM, V4 (Wound Care LPN) said R1 recently readmitted from the hospital with several wounds and some moisture-related skin break down to his left buttock that extended to his right buttock. V4 then said on 11/29/2023 during wound rounds, they noted R1's low-air loss (LAL) mattress to be deflated. V4 added that upon skin assessment, he noted the previous area of moisture break down had worsened into an unstageable pressure injury. V4 (Wound Care LPN) then said that R1's pressure injury was caused by his moisture related skin break down secondary to the mattress malfunction.	{S9999}		

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{S9999}	Continued From page 5 On 12/05/2023 at 1:10 PM, began second floor observations for repositioning of R1. At 1:15 PM, observed R1 lying in same position as above and sleeping. Head of bed was elevated approximately thirty degrees and R1's left arm hanging off the side of the bed. At 2:00 PM, observed two staff members enter R1's room and close the door then exited room at 2:04 PM. At 2:05 PM, observed R1 asleep lying in bed on his back with his knees facing towards the wall/room door, head of bed was flat. On 12/05/2023 at 02:58 PM, V15 said (Certified Nursing Assistant) said he always works day shift on the second floor. He then said residents on second floor are turned and repositioned every two hours except those who ambulate per self. He added that the facility used to have a turning program with schedules posted but "those haven't been up for a while". When asked which residents have wounds, V15 said he knows who they are and that they should be turned every two hours because of the length of time he's worked here but new staff might not know what to do. He added that when residents are turned, they are to be turned side to side, they usually on their backs at mealtimes. When asked when the last time was that R1 was turned and repositioned, V15 said he was last turned around noon and that he is going now to turn resident after he finds his helper. At 3:05, R1 remained in same position as previous, on his back with bilateral knees facing wall/room door. On 12/06/2023 at 10:00 AM, observed R1 lying in bed on his back slightly turned onto his left side, both knees facing room door, with two positioning wedges now placed behind his back and buttocks areas. Observed wound care to left buttocks at this time with V4 (Wound LPN) and V16 (Wound	{S9999}		

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{S9999}	Continued From page 6 Nurse Practitioner). At 10:06 AM, V4 said indicated R1's wound had slough and necrotic tissue throughout wound bed with small amount of granulation tissue around wound edges. V16 first measured R1's wound and said wound size is nine centimeters x seven centimeters then proceeded to debride the wound. At 10:12 AM, V16 (Wound NP) said R1 initially had moisture-associated skin damage (MASD) and is bedfast. He then said last week they noted a bed malfunction that worsened R1's MASD and caused this current pressure injury. V16 added that he ordered labs last week to rule that out as a factor but R1's lab results were normal. 2. R2's face sheet indicated resident admitted o facility on 11/21/2023 and has a past medical history not limited to: nontraumatic subarachnoid hemorrhage, dependence on respirator, protein-calorie malnutrition, and pressure ulcers. R2's quarterly Minimum Data Set (MDS) Section M dated 11/30/2023 indicated resident is at risk of developing pressure ulcers/injuries, currently receives pressure ulcer/injury care to his unstageable pressure ulcer/injury, has a pressure reducing device for bed, but is not on a turning program. R2's active physician orders reads in part: skin check every shift and as needed for prevention. report to MD/NP and wound care team for any skin alteration; wound treatment to sacrum: cleanse with normal saline, paint with betadine, cover with xeroform foam or bordered gauze daily and as needed; low air loss mattress at all times; Palliative care evaluation needed. No active order found for a turn/reposition program. R2's care plan with date initiated of 11/21/2023 reads in part: at high risk for impaired skin	{S9999}		

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{S9999}	Continued From page 7 integrity related to chronic disease process/comorbidities, (dependence on respirator/ventilator, anemia, encephalopathy, protein-calorie malnutrition, impaired mobility and incontinence). Interventions include: low air loss mattress at all times; position resident to reduce causes of friction or shear; utilize pillows or foam wedges to avoid direct contact with bony prominences; turn/reposition every two hours not included. R2's wound assessment report completed by V4 (Wound Care Nurse/LPN) dated 12/4/2023 5:50 PM indicated R2 had an unstageable maroon colored pressure wound to her sacrum that measured five centimeters x seven centimeters x. ten (.10) centimeters (length x width x depth). R2's skin/wound note dated 11/29/2023 16:34 reads in part: noted sudden pressure injury likely Kennedy ulcer due to maroon color, blistering formation and butterfly like shape. Noted resident is on palliative care. Resident wound looks like a skin failure due to declined medical condition. On 12/04/2023 at 12:30 PM observed R2 asleep in bed while lying on her back. Tube feeding in place and infusing with no issues or concerns identified. At 12:32 PM observed low-air loss mattress in place to R2's bed with weight setting at "350 pounds" and the "low pressure" alarm was sounding. At 12:34 PM V14 (Licensed Practical Nurse) said when the alarm sounds, it indicates that the air pressure within the mattress in low. V14 then proceeded to turn weight setting down to "120 pounds", then she pressed down on the air mattress to several areas to top and bottom of mattress. The alarm then had stopped sounding. Noted a flattened pillow partially beneath R2's left mid back area.	{S9999}		

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{S9999}	Continued From page 8 On 12/05/2023 at 11:13 AM, V4 (Wound Care LPN) said R2 developed a maroon-colored blistering wound that was identified on 11/29/2023. He added that R2's bed should not have been set at 350 pounds and indicated the mattresses should be set at a resident's appropriate weight because if the mattress is too firm/hard or too soft, can cause skin alterations and/or further skin breakdown. V4 then said when the low pressure alarm is sounding, that indicates a malfunction with the air mattress and indicated that he will put in a work order for R2's mattress. At 11:21 AM, observed R2 lying in bed on her back with a pillow under her back and partially facing room door (Wound care was previously performed). R1's last recorded date on 11/21/2023 21:22 indicated her weight was "94.2" pounds. On 12/06/2023 at 10;14 AM, V16 (Wound NP) then said any resident should be placed and be on a turning/repositioning program who are at risk for pressure injuries including R1 due to his history of and current wounds upon his recent readmission. On 12/06/2023 at 1:40 PM, V20 (Central Supply) said he orders or rents the air mattresses, places them on the bed after they arrive and inflates them to check for any issues. He added that he does nothing more with the mattresses unless an issue is reported, or it's no longer needed for use. When asked is there was a maintenance schedule for an air mattress, stated he was not aware of any then provided manufacturers paperwork. No schedule was indicated. On 12/06/2023 at 1:55 PM, V1 (Administrator) and V2 (Director of Nursing/DON) indicated a bed and/or mattress audit was initially completed on	{S9999}		

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{S9999}	Continued From page 9 11/29/2023 that revealed a total of seven low-air loss mattresses were malfunctioning that included R1's. They added that since the audit, the facility has rented twenty-four new air mattresses and have purchased 15 new air mattresses and replaced all those which were malfunctioning. At 2:00 PM, V2 added that education was done for all staff on 11/29/2023 on checking for proper functioning of air mattresses/equipment and who to contact if an alarm is sounding because this wasn't previously being done. She also said that audits are performed three times weekly by members of management team to check for any bed/machine malfunctions. At 2:12 PM, V2 (DON) said facility has a turning and repositioning program in which residents are turned/repositioned every two hours. She added that the restorative team was instructed to assist with turning/repositioning when nursing staff are behind schedule. Skin Condition Assessment & Monitoring-Pressure and Non-Pressure policy last revised 06/08/2018 reads in part: Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the aide. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. Wound Assessment/Measurement: 6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care.	{S9999}		

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{S9999}	Continued From page 10 Pressure Ulcer Prevention policy last revised 01-15-2018 reads in part: Purpose: To prevent and treat pressure sores/ pressure injury. Guidelines: 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. 5. Turn dependent resident approximately every two hours or as needed and position. 7. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation. Wheelchair residents may be instructed to shift weight from one buttock to the other. 11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated. (B)	{S9999}		