(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
JUBY EAR OF CONTROL OF THE PROPERTY OF THE PRO		A. BUILDING:		C			
		IL6012595			, 5/2024		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ELEVATE	E CARE ABINGTON		NVIEW ROA	D			
0(4) IB	CLIMMA DV CTA		W, IL 60025	DDOVIDEDIS DI ANI OF CORDECTI	ON	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Facility Reported In 3/25/24- IL171561	cidents of:					
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a) 300.1210b) 300.1210d)6)						
	Section 300.610 Resident Care Policies						
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conformed and othe policies shall complicate the facility and shall shall be facility and shall facility.	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed					
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care					
	care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/15/24 **Electronically Signed**

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
				С			
		IL6012595	B. WING		04/0	5/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ELEVATI	E CARE ABINGTON		NVIEW ROA W, IL 60025	D			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
S9999	Continued From page 1		S9999				
	care needs of the re	esident.					
	 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 requirements are not met as evidenced by:						
	failed to ensure a re supervised and ass 1 of 4 residents (R1 sample of 7. This fa	and record review, the facility esident at risk for falls was sisted while in the bathroom for I) reviewed for safety in the ailure resulted in R1 being sent sustaining a laceration to his d staples.					
	The findings include	e:					
	was admitted to the diagnoses includes Parkinson's disease Lewy bodies, deme abnormalities of ga Data Set (MDS) da severely impaired of dependent on staff hygiene, shower/ba off footwear, and pe plan initiated on 7/3 for falls due to gene	cord dated 4/5/24 shows he a facility on 11/15/23. R1's , but are not limited to, a, neurocognitive disorder with antia, left foot drop, and it and mobility. R1's Minimum ated 1/31/24 shows R1 has a cognition and is completely assistance for toileting assistance for toileting ath, dressing, putting on/taking arsonal hygiene. R1's care at 1/23 shows he is at high risk aralized weakness and ant secondary to dementia and					

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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		
			A. BUILDING:		,	C	
		IL6012595	B. WING			5/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ELEVATE	CARE ABINGTON		NVIEW ROA W, IL 60025				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
	On 4/5/24 at 10:50 Assistant (CNA), sa (3/25/24) that eveni PM. V8 said he was sat R1 on the toilet. R1's roommate and R1, R1 had gotten of floor in the bathroor said R1 needs assidoes not walk, he is have someone with bathroom. On 4/5/24 at 11:02 (RN), said he was t (3/25/24). V9 said a he went to R1's room is room outside of was bleeding and haceration to the basaid they called 911 V9 said R1 is a fall assistance for toilet with a staff member and should not be in he was still in the fathe hospital. V9 said R1's Nurse's Note of shows the CNA obswith noted bleeding and when the nurse can laceration was rand abrasions to the the paramedics for acute care hospital	minor/serious injury. AM, V8, Certified Nursing aid he was taking care of R1 ing after dinner around 6:30 is getting R1 ready for bed and V8 said he left R1 to attend to a when he returned to assist off the toilet and was on the m with his head bleeding. V8 istance with everything, he is a fall risk, and he needs to him when he is in the AM, V9, Registered Nurse he nurse when R1 fell a CNA came and got him and im. R1 was lying on the floor in the bathroom. V9 said R1 ad a five-centimeter (cm) ck, right side of his head. V9 and sent R1 to the hospital. risk and is dependent of staff ing. V9 said R1 needs to be rewhen he is in the bathroom in the bathroom alone. V9 said acility when R1 returned from it R1's head laceration was	\$9999				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

IL6012595 B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(X3) DATE	SURVEY LETED
IL6012595 B. WING	AND PLAN OF CORRECTION		IDENTIFICATION NOWBER.	A. BUILDING:			
ELEVATE CARE ABINGTON 3901 GLENVIEW, IL 60025 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 3 6:33 AM shows R1 returned from the emergency department at 11:10 PM (on 3/25/24) with sutures and staples on his right occipital area. The facility's Long-Term Care Facility & IID-Serious Injury Incident and Communicable Disease Report dated 3/29/24 at 3:00 PM shows R1 had a fall with physical harm or injury on 3/25/24 at 6:30 PM. It also shows staff interviews indicate R1 was assisted to the bathroom whereby he was left sitting on the toilet unattended while the CNA remained outside the bathroom door. When the CNN heard a "thud," the CNA returned to find R1 on the floor. R1 was transported to the emergency department via 911 ambulance and later returned to the facility with staples to his head laceration. The facility's Fall Prevention Program Policy (revised 11/21/17) shows, "Residents who require staff assistance will not be left alone after being	IL6012595		B. WING				
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XS)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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