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ELEVATE CARE NORTH BRANCH	6840 WEST TOUHY AVENUE NILES, IL 60714

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S 000	Initial Comments Complaint Investigation 2496682/IL169123	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 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. 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.	S9999		

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S9999	Continued From page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 6) All necessary precautions shall be taken to assure the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and monitoring of residents at risk for falls and with a history of falls for 3 (R1, R3, R4) of 3 residents reviewed for accident hazards in the sample; failed to follow the plan of care to prevent injuries and future falls; and failed to train staff (including agency staff) on fall risk interventions. These failures resulted in all 3 residents requiring emergent transfers to the hospital emergency department. R1 sustained a left shoulder fracture; R3 sustained a non-displaced sacral fracture with required	S9999		

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hospitalization; and R4 sustained a left tibia/fibula (ankle) fracture with required hospitalization and surgical intervention.

Findings include:

On 3/1/24 at 1:22 PM, V2 (director of nursing) presented surveyor with their fall incidents log in the past 90 days which showed a total of 45 falls. V2 indicated V15 (Restorative LPN/Falls Nurse) was the facility's designated fall nurse in charge of (implementing, monitoring and assessment) the fall prevention program.

On 3/1/24 at 2:21 PM interview with V15 (restorative nurse) disputes V2's statement he was the "Fall Nurse". V15 stated, "I am the Restorative nurse here, not the "Fall nurse". My title is Restorative nurse, and I am not in charge of falls; Is what they told you? I'm just part of the team." Surveyor asked to clarify his role. V15 stated, "When I come in here, I check if there are any falls and report from nurses. I go to the nursing stations to get initial information about any fall, and we bring it up in the morning huddles. I do continuous in-service fall training and we do it every orientation for new employees." Surveyor asked when V15 conducted last fall risk training. V15 stated, "I can't recall when the last time it was done but we have monthly town hall meetings about general nursing stuff". Surveyor asked V15 to provide any documentation showing when in-service training was last conducted by him. V15 indicated he would check but never came back to provide surveyor with said training materials.

1. R1 is an 88 year old with diagnosis listed in part with chronic kidney disease with heart failure, atrial fibrillation, congestive heart disease and

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S9999	Continued From page 3 mild cognitive impairment. Care plan dated 11/22/23 reads in part, "(R1) has potential risk for falls. Gait/balance problems, Incontinence, Psychoactive drug use, Vision/hearing problems related to glaucoma, CHF, Hypertension, Atrial fibrillation. Goal: R1 will not sustain serious injury through the review date. Interventions: Keep furniture in locked position; Keep needed items, water, etc. in reach; Maintain a clear pathway, free of obstacles; Evaluated for adaptive equipment and supplies. Re-evaluate as needed for continued appropriateness and to ensure least restrictive device or restraint. R1 educated on using his walker or wheelchair per therapy recommendations; Encourage to participate in activities promote exercise, physical activity for strengthening and improved mobility; Be sure call light is within reach and encourage resident to use it for assistance as needed; Ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair". Fall assessments dated 11/29/22, 12/6/22, 2/28/23, and 12/24/23 all showed R1 to be at "High Risk for Falling". Fall assessments dated 11/21/22 and 12/24/23 showed R1's history of fall incidents. On 3/1/24 at 10:35 AM, surveyor entered the locked dementia unit behind two double doors. R1 was in his room seated in his wheelchair, appearing very disoriented and unable to follow any line of questioning. R1 was fully dressed but had socks that appeared to have no grip on the floor as R1 was sliding his feet as he appeared stuck in between the bathroom and closet doors trying to maneuver himself out of the room. Surveyor exited the room in search of an aide or	S9999		

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nurse and asked V4 who identified herself as the social worker and unit manager. Surveyor asked V4 where the nurses or aides were. V4 stated, "It should be V8 (agency LPN) on that side taking care of R1, but I don't know where she is." Surveyor approached V7 (LPN) who indicated there were two nurses on the unit with 50 residents and 4 CNA's. V7 stated, "I don't know where V8 is, but I don't take care of that side. I think V8 is probably in one of the resident rooms."

On 3/1/24 at 11:45 AM, surveyor asked the V8 agency nurse about the unit, V8 stated, "I know this is the dementia unit, but I don't know if I can tell you anything else because I am agency here." Surveyor asked if she was informed of any residents at risk of falls, V8 stated, "No. I wasn't told anything". Surveyor asked if V8 received any endorsement from the nurse when she came in. V8 stated, "No I wasn't told anything, like I said." Surveyor asked if V8 received any orientation about the residents specific to the unit. V8 stated, "No. I just pick up the shift and I work it. I don't know where they put me, I just go where I'm told."

The facility's internal investigation, along with the surveyor's investigation of R1's fall showed the following:

On 12/24/2023 00:42 (12:42 AM) V5 (LPN) wrote in part: "Nurses Note. 11:10 PM, CNA doing rounds found the patient (R1) on the floor by the side of the bed. Patient found lying on the left side of the body with the right leg straight and left leg slightly flexed. "

V5's signed statement on 12/26/23 obtained by V2 (director of nursing), reads in part, "I (V5) came to my schedule shift 12/23/23. Once I got into the unit, (V17) agency nurse was rushing to

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S9999	Continued From page 5 go home. Both of us did the medication count and she handed keys and left. CNA then came to me and mentioned the patient was observed sitting on the floor. I immediately came to the room and observed patient sitting on the floor. Patient stated, "I don't remember how I fell down. Doctor on call notified and ordered pain medication and x-ray, neurological checks taken and recorded." On 3/1/24 at 3:10 PM, Surveyor interviewed V5 who stated, "(R1) was more of a newer patient for me because I was rotating in the facility, and I think it could have been the first time I was taking care of him." Surveyor asked if V5 was informed of R1's fall risk or plan of care to prevent R1 from falling. V5 stated, "No, like I said I was pretty new to the unit (referring to the dementia unit)." Surveyor asked if V5 received any endorsement from the outgoing agency nurse (V17). V5 stated, "No. As I mentioned in my statement to the DON, agency nurse was in a rush to get out of there and she quickly did the medication count and just handed over the keys and left. I'd say about 30 minutes into my shift, my CNA called me to the room and said she found the resident on the floor beside his bed. I called the doctor, and he ordered x-rays and neuro checks." Surveyor clarified whether the facility staff informed her of R1's fall risk. V5 stated, "I only found out afterwards when he fell but I didn't know. I was not told at all he was a fall risk. I only found out as soon as the other nurse came from the other unit told me." Surveyor asked V2 (DON) the identity of the agency nurse. V2 indicated it was V17 (Agency LPN). V2 stated, "We no longer use V17 ever since incident." Surveyor requested contact information for V17 but was not provided any during the survey.	S9999		

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S9999	Continued From page 6 On 1/2/2024 at 09:32 AM V16 (Nurse Practitioner) wrote in part, "Progress Notes. Chief Complaint/Reason for this Visit: Debility, COVID 19 infection, recent fall with acute fracture of clavicle and left acromion, lab review. HPI (History of Present Illness) Relating to this Visit: Informed by staff today patient with recent diagnosis of COVID infection and recent fall with acute fracture of clavicle and left acromion. Patient was evaluated in the ED on 12/25/23." Hospital records dated 12/24/2023 authored by V18 (hospital ED physician) showed in part, "HPI (History and Present Illness): Patient is an 88 year old male who presents to the ED with fall 2 days ago. Patient is a nursing home resident, was reporting shoulder pain and had an x-ray today which reportedly showed a left shoulder fracture. Patient currently reporting left shoulder and left hip pain. Indication: 88 year old male fall, trauma. Findings: Left clavicle: There is an acute mildly displaced and mildly angulated oblique fracture through the mid shaft of the left clavicle. There is mild posterior apex angulation and slight overriding of the major fracture fragments. Patient was placed in a sling his upper extremities are neurovascularly intact given a Norco for pain." 2. R3 is an 81 year old with diagnoses including history of falling, Parkinson's Disease, Osteoarthritis, and Dementia. R3's fall risk assessments dated 12/8/23, 1/2/24, 1/24/24, and 2/24/24 all showed the resident to be at "High Risk for Falling". Facility fall incident report dated 2/21/2024 authored by V2 (director of nursing) reads in part,	S9999		

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"81 year old female with diagnoses including history of falling, Parkinson's Disease, and Dementia. Her BIMS is at 04 (severe cognitive impairment). She requires partial assistance with transfers. CNA on duty stated resident was being assisted with transfer from the wheelchair to the bed to provide peri care. During transfer resident became agitated and attempted to push herself away from CNA. Resident's shin came into contact with bed frame. Resident sent out to hospital for evaluation and treatment. Resident admitted for left tibia/fibula fracture and returned to facility post ORIF (Open Reduction Internal Fixation) surgery on 2/24/24, weight bearing as tolerated with boot to left lower extremity."

On 3/1/24 at 11:45 AM, R3 was seated in a high back wheelchair in the dining room dressed in hospital gown and black colored left leg brace. In one corner of the dining room sat V9 (agency CNA) with her focus directed at her laptop computer. V9 was asked her responsibility. V9 indicated she was there to monitor the residents. Surveyor asked how V9 was able to do this while focused on her computer. V9 did not respond and got up and walked away from surveyor. Surveyor approached R3 who appeared confused and was speaking nonsensical words spoken in Spanish and could not follow any line of questioning from the surveyor. V19 (activity aide) was asked her responsibility. V19 stated, "I'm doing activities for the residents and we're doing trivia now." Surveyor asked who the residents were currently in the dining area were considered fall risk residents, V19 stated, "I don't know."

On 3/2/24 at 10:40 AM, surveyor entered the locked dementia unit and approached V13 (Agency LPN) and asked about the unit. V13 stated, "I'm an agency nurse and it's my first time

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here." Surveyor asked if V13 knew the type of unit she was in. V13 stated, "No. No one told me anything." Surveyor asked if V13 received any endorsement during shift change, V13 stated, "No. The nurse was already gone when I got here." Surveyor clarified if V13 received any sort of orientation or training for the unit and/or whether V13 was informed of any residents at risk for falling and specifically for R1 and R3 who were assigned to her., V13 stated, "Sorry, I wasn't told anything. I got here and was told to go here and that's it."

On 3/2/24 at 11:15 AM, V1 (administrator) was informed about the information V13 had given. V1 indicated and affirmed it was an oversight and the facility was working to fix the nursing supervisory issues.

On 3/1/24 at 1:30 PM, V2 (Director of nursing) was asked to provide investigation pertaining to 2/21/24 incident in order to identify staff involved. V2 indicated to surveyor there was no information found with no explanation.

Hospital record dated 2/21/24 reads in part, "This patient is an 81 year old female with a past history significant for Depression, hypertension, Parkinson's, Senile Dementia. Presents to hospital ED from nursing home after falling from bed with left Tibial Fracture and complains of Pain in left lower leg. Previous admission was for a right hip fracture a couple weeks prior to this admission. Further evaluation and work up as follows: Status post Fall, left leg pain, Left distal Fibula Fracture, Anemia, Chronic stable right hip fracture. 2/21/24 planned for ORIF of left Pilon with Intramedullary Nailing of Left Distal Tibia Fracture."

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S9999	Continued From page 9 3. R4 is an 89 year old cognitively impaired resident with diagnoses including Alzheimer's Disease, Dementia, and hypertensive kidney disease. R4's fall assessments dated 3/11/23, 9/7/23, 1/22/24 and 1/27/24 all assessed R4 as "High Risk for Falling". R4's history of falls showed the resident falling on 3/11/23, 9/7/23 and 1/22/24. Care Plan dated 12/13/23 reads in part, "(R4) is at risk for falls related to impaired cognition with poor safety awareness, risk factors: Alzheimer's Disease, Dementia, History of falls, Anemia, polypharmacy with psychoactive medications and its potential side effects and recent fall. Goal: Resident will resume usual activities and will lessen fall incident occurrences and or impact of injury if fall occurred. Interventions: Falling Leaf program for increased awareness of fall risk and augmented fall prevention approaches; Keep furniture in locked position; Keep needed items, water, etc. in reach; Maintain a clear pathway, free of obstacles; Place call light within resident's easy reach and use for assistance; Room close to nurses' station; Remind resident to use the call light to call for assistance for transfers and ambulation; Encourage to participate in activities promote exercise, physical activity for strengthening and improved mobility; Ensure resident is wearing appropriate footwear when ambulating." Facility incident report dated 1/12/24 submitted by V2 (director of nursing) reads in part, "(R4) was observed laying on the floor next to her bed with feet closest to bed and head closest to door. Noted to have pain on right knee and limited	S9999		

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mobility on right lower extremity. She (R4) is unable to say what happened. Received order to transfer to ED for further evaluation. Possible fracture on right sacral Aral noted per CT (Cat Scan)."

Hospital record dated 1/22/24 showed in part, "Hospital course: (R4) is an 89 year old female admitted 1/22/2024 for Urinary tract infection, Fall, Back pain unspecified back location. Status post Unwitnessed Fall Possible Sacral Alar Fracture. 1/23/2024 Orthopedics consult about possible Alar Sacral Fracture and state no restrictions, is healing and non-displaced. (Non-displaced fractures are still broken bones, but the bone pieces weren't moved far enough during the break to be out of alignment, but still considered a fracture.)

Observations conducted on 3/1/24 at 10:37 AM showed R4 remaining in bed behind a closed door with no direct line of sight from staff. At 10:45 AM, Surveyor asked V7 (LPN) if R4 was one of her residents. V7 stated, "Yes. This side is my unit (pointing down one hall) and I'd say we have about 50 residents and all of them have dementia because this is the dementia unit". Surveyor asked who the residents were at risk for falls. V7 stated, "Most of them here are, maybe all of them." Surveyor asked if she was provided any in-service training related to fall prevention. V7 stated, "I have but I don't remember when."

On 3/2/24 at 10:45 AM, R4 remained behind a closed door of her room. When surveyor entered, there was a care giver was inside the room with R4. R4 was in the bathroom standing upright and was bending to squat over the toilet. R4 was fully naked and per V14, she assisted R4 to the bathroom so R4 could use the toilet. R4 was

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observed barefoot and naked with no foot wear or slip resistant socks worn. The resident appeared unsteady as she squatted down and was taking toilet paper to clean herself while V14 was at the door watching and not assisting R4. Surveyor asked V14 if she worked at the facility. V14 stated, "I'm her care giver but I'm a CNA." Surveyor asked why she did not ask for facility staff to assist resident to the bathroom. V14 stated, "I can't find anyone." Surveyor asked if V14 used the call light for staff to assist the resident to the bathroom. V14 stated, "No." Surveyor asked if V14 knew if resident was at risk for falls and/or what those precautions were. V14 stated, "I don't know, please ask (V4)" Surveyor clarified whether the facility provided her training on fall prevention. V14 stated again, "I don't know, ask (V4)."

Hospital record dated 2/21/24 reads in part, "This patient is an 81 year old female with a past history significant for Depression, hypertension, Parkinson's, Senile Dementia. Presents to hospital ED from nursing home after falling from bed with left Tibial Fracture and complains of Pain in left lower leg. Previous admission was for a right hip fracture a couple weeks prior to this admission. Further evaluation and work up as follows: Status post Fall, left leg pain, Left distal Fibula Fracture, Anemia, Chronic stable right hip fracture. 2/21/24 planned for ORIF of left Pilon with Intramedullary Nailing of Left Distal Tibia Fracture."

Policy dated 11/21/17 titled "Fall Prevention Program" reads in part, "To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of

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ELEVATE CARE NORTH BRANCH	6840 WEST TOUHY AVENUE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The program includes the following components: Methods to identify risk factors; Methods to identify residents at risk; assessment time frames; Use and implementation of professional standards of practice; Immediate change in interventions were successful; Notification of physician, family representative; Communication with direct care staff members. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented an d trained in the Fall Prevention Program; The nurse call device will be placed within the resident's reach at all times; The resident's personal possessions will be maintained within reach when possible; The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards; Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or char and provide care as assigned in accordance with the plan of care; Call lights are answered promptly; Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet; Nursing personnel will be informed of residents who are at risk of falling; Foot wear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid." (A)	S9999		