

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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
S 000	Initial Comments Facility Reported Incident Investigation of 2/21/24 IL170398 Facility Reported Incident Investigation of 4/18/24 IL172277	S 000		
S9999	Final Observations Statement of Licensure Violations: 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. 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	S9999		

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

TITLE

(X6) DATE

Electronically Signed

06/26/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure that a resident's hospital bed was in good working order and in condition to be used safely. This failure applied to one (R3) of three residents reviewed for falls and resulted in R3 sustaining a fall from bed that resulted in R3 sustaining a right arm (humeral) fracture.</p> <p>Findings include:</p> <p>R3 is an 80-year-old female with medical diagnoses that include (but not limited to): Disruption of external operation (surgical) wound, unspecified fracture of the lower end of right radius, vascular disorder of intestine, presence of cardiac pacemaker, difficulty in walking, abnormal posture, weakness, and history of fall.</p> <p>R3 was admitted to the facility on 03/15/24 and discharged after transfer to hospital on 04/18/24.</p> <p>R3's Care Plan includes the following:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 2</p> <p>- Requires set up to dependent assist of 1-2 staff w/her functional mobility, transfer, toileting, eating, dressing & personal hygiene related to impaired mobility secondary to dx of fracture of lower end of right radius, wound dehiscence (abdomen), morbid obesity. She is ambulatory w/walker and partial to dependent assist related to weakness on both lower extremities. Date Initiated: 3/18/24, Revision on: 3/20/24; Interventions include: Resident usual performance: Dressing - lower body dressing - substantial/max assist; putting on/taking off footwear - dependent; Resident usual performance: Bed Mobility - sit to stand - partial/mod assist ...Date Initiated: 3/18/24, Revision on: 3/20/24.</p> <p>- At risk for falls Deconditioning. Initiated: 3/18/24, Revision on: 3/20/24; Interventions include ...Keep furniture in locked position. Initiated: 3/18/24.</p> <p>Facility provided facility reported incident documenting that R3's normal baseline - alert/oriented x4, she is able to ambulate and transfer with 2 person assist. On the afternoon of 4/18/24, resident c/o right arm pain to assigned nurse. PRN medication was administered with little relief. MD and POA were notified. MD ordered resident to be sent to local hospital for further orthopedic evaluation. Per hospital update received on 4/19/2024, x-ray result of the right elbow showed a traverse fracture of the right humerus ...(R3) had a fall on 4/4/24 and was sent to local hospital for evaluation. X-ray of the right elbow was done on 4/5/24, however the transverse fracture was not seen in the prior elbow study. This was documented several times in the hospital records. Resident came back same day 4/5/24 ...</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 3</p> <p>Facility provided documentation of Post Fall Huddle for R3 for fall dated: 4/4/24 which documents: Event: Resident was sitting in bed putting on her shoes with CNA assisting. Per resident, the bed moved making her fall from bed; Root Cause: Rubber part of wheel was worn causing less brake traction ...</p> <p>Hospital record for date of service 4/5/24 HPI documents: 80-year-old female accidentally fell onto her right shoulder apparently the bed was not locked, and she fell ...Chief Complaint includes: Patient reports she was putting on her shoes at the edge of the bed, the bed was a lot [sic], the bed slid out from underneath her, patient landed on her right side on her right shoulder and her right elbow. A lidocaine patch is in place without significant improvement in symptoms ...</p> <p>Hospital record for date of service 4/19/24 documents: X-ray Humerus (RT): Impression: Transverse fracture through medial lateral epicondyle of the distal humerus as described above. This is not seen on the prior elbow study dated 4/5/24 ...Ortho/Heme: Right distal humerus fracture and acute on chronic blood loss anemia due to hemi arthrosis of right shoulder. These findings are acute based on x-ray on this admission but may have been suffered from mechanical fall ~ 2 weeks ago. Imaging at that time was negative ...</p> <p>On 6/10/24 at 3:03PM V25 (CNA) confirmed that they witnessed the fall in question that R3 sustained on 4/4/24. V25 said, I was helping (R3) get her shoes on. She was sitting on the edge of the bed. When I bent down to get her shoes, I think she tried to stand up. I don't know if it was her body weight or that her legs twisted, but somehow when she leaned on the bed it slid.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 4</p> <p>When the bed slid, she fell on the floor. I think she landed on her right side because that was the side that she was complaining about after she fell. I immediately pulled the call light for staff to come assist. She tried to get up from the floor, but I told her not to get up because we should wait for the nurse to come and assess her first. The two or three nurses who were working, all came in the room and then I'm not exactly sure what happened. She was complaining that her right shoulder was hurting. The bed was locked but I don't know how it slid over.</p> <p>On 06/07/24 at 1:50PM V1 (Director of Nursing) said, the CNA was helping (R3) get dressed and she fell because the wheel of the bed was damaged. It popped off and it caused her to fall off the bed. Then it happened with another resident, and we knew we had to do a full facility sweep. The beds are old and so we checked all of the beds in the facility and identified any that were old and needed to be replaced. The cost is over \$400 per wheel so we had to get approval from corporate because I told them I could not have any more injuries because of this problem. We recently finished replacing all the damaged beds.</p> <p>On 6/8/24 at 10:52AM, V1 added that R3 complained of post fall pain, I think 3/10 and right arm pain the next day. We ordered a STAT x-ray, but the company was taking too long so we sent her to the hospital for the x-ray. She already had a fracture when she got here but when we sent her out to the hospital the x-ray came back inconclusive. V1 then provided documentation of 4/5/24 x-ray being inconclusive and provided documentation of when R3 was sent to hospital second time for further testing of right arm/shoulder pain.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 5</p> <p>06/08/24 at 10:11AM V7 (Director of Environmental Services) said, it was reported to me that one of the beds was damaged, I think it was in April. The brakes were not holding. When we checked the bed, two of it's wheels were worn. The rubber on the wheels was very thin and worn. I removed the bed and put a different bed on the room, ordered new wheels, and replaced them. After that, I did an audit on the entire building and checked every single bed. We found a few more like that, we removed them from the units, and we replaced the actual wheel. There was a second one on 5/5/24 Room 104-B that we found during the audit. The original one reported to me was (R3's room) on 4/4/24 (V7 showed surveyor tracking app on his phone with date). The order requests are put in the app and then we go and follow up. The one in May was the same issue and that one was replaced as well. I ordered a bunch of wheels to have them on hand and we replaced them to avoid this problem from happening.</p> <p>Facility provided log of Quarterly Preventative Maintenance on Hospital Bed, dated 4/5/24 which documents "yes" for the question "Are the wheels of the bed in good working condition" for rooms 103A, 104C, 105A, 113C, and 115A. Comments section on the same log then documents that on 4/17/24 wheels were replaced on beds for the above listed rooms.</p> <p>Facility provided a copy of their Maintenance Policy (undated), which reads: Purpose: To ensure that the building (interior and exterior), grounds, and equipment are maintained in a safe and operable manner. Responsibility:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003586	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY NORTHBROOK, IL 60062
--	---

(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	<p>Continued From page 6</p> <p>Maintenance Director, Administrator Policy: It is the policy of the facility to provide a safe, accessible, effective, and efficient environment of care that is consistent with its mission, services and law and regulations. Guidelines: 1. The department shall be supervised and managed by a qualified Maintenance Director. 2. Sufficient staff are oriented to, educate about the environment of care, and possess knowledge and skills to perform duties consistent with management plans ... 4. The department shall maintain all equipment and supplies in a safe and operating condition. Maintenance supplies shall be provided and inventoried in sufficient quantity to assure equipment and systems are maintained in good working order ...</p> <p style="text-align: center;">(B)</p>	S9999		