STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145171	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Northbrook	270 Skokie Highway Northbrook, IL 60062

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41692 Based on interviews and record reviews, the facility failed to follow its own policy by not providing the services of an onsite beautician, this failure affected four (R4, R5, R6, and R7) of four residents reviewed for resident rights. Findings include: On 6-8-2024 at 1:30 PM V20 (R4's family member) said, R4 cannot be scheduled to see a barber at the facility because they do not provide the services of a barber or a beautician, for a very long time, I can send money for R4 to be scheduled with the barber because R4 likes to have a short hair. On 6-8-2024 at 10:50 am R4 said, my hair is long now, I am waiting for my family to take me out to get it groomed because not everyone can take care of my hair (referring to the curly hair), we do not have a barber here in the facility for a long time. R5 is a [AGE] year-old female originally admitted on [DATE] with medical diagnoses that include and are not limited to: asthma, chronic pulmonary disease, and diabetes. MDS- BIMS: 15/15 dated 5-3-2024. On 6-8-2024 at 11:20 am, R5 said, we have not had any beautician for several years, it would be nice to have one because my hair is long and needs to be cut and styled. R6 is a [AGE] year-old female originally admitted on [DATE] with medical diagnosis that include and are not limited to: chronic obstructive disease, schizoaffective disorder, and anxiety disorder. MDS- BIMS: 15/15 dated: 4-29-2024. On 6-8-2024 at 11:30 am R6 said, we have not had any beauticians for several years, we had one before, and is nice because they can cut and fix the hair nicer. R7 is a [AGE] year-old female originally admitted on [DATE] with medical diagnosis that include and are not limited to: schizoaffective disorder, bipolar disorder and hypertension. MDS- BIMS: 14/15 dated: 4-19-2024. On 6-8-2024 at 12:20pm R7 said, I need to go out with my family to have my hair cut and color, they do not have any beautician here to give us the services. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6-8-2024 at 9:20am V6 (Director of Social Services) said, we do not have a barber for some time. On 6-8-2024 at 11:40am V16 (Certified Nurse Aide) said, we do not have a beautician, if the family or the patient asks the nursing staff to cut the hair of any of the residents, we can do it, I am not licensed beautician, but I had done it for a very long time and I do a very good job. On 6-8-2024 at 11:45am V8 (Life Enrichment Director/Activity Director) said, we have a beauty salon, but I have not seen any beautician since I started working here more that 11 months ago. On 6-10-2024 10am V19 (Administrator) said, we do not have a beautician now, we should have one available if the resident wants the services on site. On 6-10-2024 at 12:40pm V21 (Social Worker) said, we do not have a beautician for almost a year, we have a beauty shop but not a beautician. 6-10-2024 at 1:30pm V19 (Administrator) provided a written statement that reads: the last time we had a beautician was on May 11th, 2023. V1 (Director of Nursing) provided a policy titled: On-site Health care services dated: 9-2015, reads: to make available on-site health care services, it is the policy of the facility to assist residents in arranging health services on site services available: Beautician/Barber services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33783 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. The surveyor confirmed by observation, interview, and record review that the deficient practice was corrected on 4/17/24, prior to the start of this survey, and was therefore Past Noncompliance. Findings include: R3 is an [AGE] 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. R3 was admitted to the facility on [DATE] and discharged after transfer to hospital on 04/18/24. R3's Care Plan includes the following: - 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. - 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. 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 . 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; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Root Cause: Rubber part of wheel was worn causing less brake traction . Hospital record for date of service 4/5/24 HPI documents: [AGE] year-old female accidentally fell on to 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 . 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 . 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. 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. 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 [ROOM NUMBER]-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. 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. 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: 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 . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included in-service training for staff on reporting/checking/identifying damaged equipment, audit of all beds in the facility, replacement of damaged wheels on resident hospital beds, QAPI bed maintenance review, and ongoing weekly QA audits of damaged hospital beds. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33783 Based on interview and record review, the facility failed to ensure that residents are personally seen by their physician for an initial comprehensive visit upon admission and at least once every 60 days while in the facility. This failure applied to four of four (R1, R4, R5, R6) residents reviewed for physician services. Findings include: R1 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: Myopathy, Hemiplegia and Hemiparesis following cerebral infarction. R1's primary care physician is V24 (Medical Director). R4 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: cerebral palsy, schizo-affective disorder, diabetes, and hypertension. R4's primary care physician is V26 (Medical Doctor). R5 is a [AGE] year-old female originally admitted on [DATE] with medical diagnoses that include and are not limited to: asthma, chronic pulmonary disease, and diabetes. R5's primary care physician is V27 (Medical Doctor). R6 is a [AGE] year-old female originally admitted on [DATE] with medical diagnoses that include and are not limited to: chronic obstructive disease, schizo-affective disorder, and anxiety disorder. R6's primary care physician is V27 (Medical Doctor). During the course of this investigation, while reviewing resident records for change of condition, it was noted that there was no documentation of physician progress notes for the period reviewed (over the past six months) for R1, R4, R5, and R6. Interview with V1 (Director of Nursing) on 6/8/24 at 2:30PM, V1 stated that he was not sure how often the physicians are required to see the residents. Facility was asked to provide the last two physician notes for R1, R4, R5, and R6 and the following were/were not provided: R1 - no physician progress notes provided R4 - no physician progress notes provided R5 - most recent physician notes provided were for 9/30/20 and 9/10/20 R6 - most recent physician notes provided were for 3/30/2019 and 3/22/2019 On 6/10/24 at 2:08PM, V19 (Administrator) confirmed that the above dates were the most recent progress notes for R1, R4, R5, and R6. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/8/24 at 1:17PM V24 (Medical Director) was interviewed and stated, (regarding R1), I didn't see him when he first came in because I was out of the country, but I did see him when he came back (from the hospital in April) . I document in (progress notes) but I don't know how this got missed with this patient. There is generally good documentation of my visits. I cannot give you a good explanation of why there is no note. I come in every week while I am in town. I see all the new patients and I talk to them and see them, and I see families. They know I come in on Thursdays. I am at least there 42 weeks and if I can't come in on Thursday then I change my day. I don't see long term patients very often. I just make sure that I see them every 6 months, but I tell (V1 - Director of Nursing) to let me know if I need to see anyone. (Nurse Practitioner) will see them every month and then they are seen by all sort of people - rehab, ID, cardiology. I tend to see them every 6 months or every year. I see the dialysis and ventilator patients until I see that they are stable. I do stay involved with the people who are sicker where I am able to provide a lot more help rather than the stable people who don't need to be seen as often. You can see my notes - this is an anomaly. Facility provided a copy of their Physician Services Policy (Effective Date: 11/15/23), which reads: Policy: It is the policy of this facility that each resident admitted to this facility is under the care of a physician licensed in the State and that all physician services will comply with State and Federal regulations for resident care in a licensed facility. Policy Specifications: To ensure that each resident receives proper medical care and to define the requirements and responsibilities for positions admitting and caring for residents. Responsibility: Attending Physicians, Medical Director, and Administrator Standards: 1. Physicians providing medical services in this facility will be approved by the Credentials Committee and abide by the Medical Practice and By-Laws Policies, Physician Services Policy and all other policies indicated. 2. Physicians who have facility privileges will have files maintained and periodically audited which contain the following current records: a. License b. DEA number c. Certificate of insurance d. Verification of professional standing from the Health Professional Bureau and State Medical Board e. Clinical performance evaluations f. Credentials and hospital privileges (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A physician's admission order approving or recommending that the individual be admitted to the facility shall be required for all residents. 4. Upon admission, each resident shall designate an attending physician and physician will verify willingness to attend the resident at the facility. 5. The Administrator and/or Medical Director shall ensure that all attending physicians are provided with current copies of the following policies: a. Physician Services Policy b. Resident Rights and Responsibilities c. Advance Directives Policy d. Nurse Practitioner/Physician Assistant Services e. Medical Practice Policy f. Medical Staff By-Laws g. Physician Notification Policy 6. The attending physician shall be responsible for informing the resident or his/her legal representatives, of his/her medical diagnosis, treatment and prognosis in terms and language the resident can reasonably expect to understand, and the resident shall be permitted to participate in the planning of their total care and medical treatment to the extent his/her condition permits. 7. At the time of admission, the physician must provide immediate care, i.e., medications, treatments, and diet. 8. At the time of admission or within forty-eight (48) hours thereafter, the physician will provide resident information which includes: a. Relevant past medical history b. Current medical findings c. Prognosis and Rehabilitation Potential d. Diagnosis e. Regimen of Medical Care f. Report of Physical Examination performed not earlier than five (5) days prior to admission and updated to include new medical information if the resident's condition has changed since the examination was performed. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Statement that resident is free of tuberculosis in a communicable state h. Results of a chest x-ray performed within the last six months and Mantoux test within three (3) months of admission i. Recommendation for level of care j. Mobility status k. Orders regarding permission to leave premises on LOA l. Allergies 9. The above listed requirements may be considered met if a medical referral (transfer record) accompanies the resident at the time of admission providing all required information and the physician documents in the medical record that referral reports are accurate and acceptable. 10. In the event the transfer institution does not provide the report of physical examination, the attending physician will provide sufficient written admitting medical information for the provision of care during the forty-eight (48) hour period. If a medical history and physical examination is performed with and five (5) days admission in the report is recorded in the medical record, the report will be accepted. 11. Each resident will have medical plan of care for twenty-four (24) hours a day. In the event of the attending physician's absence or in case of emergency, the physician will provide the name, telephone number or answering service number of the alternate physician. In the event it is determined that a physician is unable to fill his/her obligations of providing continuity of care, the resident and/or their legal representative will be requested to obtain alternate physician services. 12. Arrangements are made for the medical care of the resident twenty-four (24) hours a day. In the event of the attending physician's absence or in case of emergency, the physician will provide the name, telephone number or answering service number of the alternate physician. In the event it is determined that a physician is unable to fill his/her obligations of providing continuity of care, the resident and/or their legal representative will be requested to obtain alternate physician services. 13. The attending physician is responsible for performing, on an annual basis, a physical examination of each resident under his/her care. Examination will include resident vital signs and physical findings, current diagnosis, and statement that the resident is free of tuberculosis in infectious stage. 14. Blood transfusions or chemo/radiation will only be administered in the facility if: a. Contracts for both services are current and signed by authorized individuals b. There is evidence of staff education prior to service being provided (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. Written orders for all medications and treatments, in sufficient detail for the provision of care, shall be prescribed by the physician upon admission and updated throughout the resident's stay. All orders and treatment shall be reviewed and personally signed and dated by the physician. The physician shall assure that current diagnoses are available to support care and treatment. 16. Telephone orders shall be signed on the physician's next visit. Admission verbal orders shall be countersigned within forty-eight (48) hours of admission. Signed orders received by fax machine do not require re-signing. 17. Signature stamps are not acceptable for physician orders and standing orders may not be used. 18. The attending physician shall write a progress note at the time of each resident visit and review the resident's total program of care, i.e., comprehensive assessments, care plans, medication and treatments and approving such by signing and dating the current order recap. 19. The physician's visit will be considered timely if it occurs no later than ten (10) days after the required date. 20. The attending physician shall certify upon admission and at each visit every 30/60 days thereafter what level of care the resident requires and document the for a change in the progress notes. 21. A physician may delegate tasks to a physician assistant, nurse practitioner or clinical nurse specialist who is under the supervision of the physician and acts within the scope of practice as defined by the state law and are authorized by Medicare Regulations. The delegating physician shall be responsible for specifically delineating assigned duties, in writing, and methods of supervision that meet appropriate statutes. (See Nurse Practitioner Policy) 22. In the event a physician and alternate physician cannot be contacted or refuse to respond to a licensed nurse, and the situation requires immediate action, the Director of Nursing or on-call designee shall be notified for direction. The Medical Director shall also be contacted when medical intervention is required. 23. Unsuccessful attempts to contact physician and his/her refusal shall be documented in the nursing progress notes by the licensed nurse making the attempts to notify the physician. 24. The physician shall be notified when an emergency arises due to medical necessity, and no do not resuscitate order is written. Licensed nurses shall initiate basic life support, call 911 and immediately transport the resident to the nearest hospital. 25. The facility shall notify the attending physician of any accident, injury or significant change in the resident's condition that threatens the health, safety, or welfare of the resident, including but not limited to abnormal laboratory values, significant change in vital signs, symptoms of infection, changes in skin conditions such pressure ulcers, weight fluctuations of 5% or more within a one-month period or 10% within six months. 26. Specific criteria shall be developed and implemented regarding physician notification upon change of resident condition. (See Nursing Procedure Manual) (continued on next page)

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Elevate Care Northbrook	270 Skokie Highway Northbrook, IL 60062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	27. Medical consults shall be obtained with concurrence of the attending physician notification and approval unless in conflict with the resident's wishes. Results and/or recommendations of all consults shall be conveyed to the attending physician in writing and consulting reports retained in the medical record. Consultant physician order shall be reported to the attending physician for approval. 28. Physician shall certify and decertify the need for Medicare skilled services in accordance with CMS requirements. Physicians may sign an initial certification and one more re-certification at the same time.