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	01/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41692 Based on interview and record review, the facility failed to follow manufacturer guidelines for the care of a Left Ventricular Assist Device (LVAD). This failure affected one resident (R1) who was emergently transferred to a local hospital for unresponsiveness and was diagnosed with complications involving a left ventricular assist device. Findings include: R1 is a [AGE] year-old female originally admitted on [DATE] with medical diagnoses that include and are not limited to: acute and subacute endocarditis, ventricular tachycardia and the presence of heart assist device-HM3 implant on 10-26-2018 and status post ventricular tachycardia (VT) ablation on three different occasions on 8-2017. Minimum Data Set (MDS) reads under Brief Interview for Mental Status (BIMS) test results dated 12-24-2024 had a result of 15/15 cognitively intact. R1 needs partial to moderate assistance with toileting. The left ventricular assist device (LVAD), also known as a heart pump, is connected to the heart and helps pump blood from the left ventricle which is the primary pumping chamber in the heart. The LVAD then helps pump blood to the rest of your body. The LVAD is considered a form of life support, it may be a life-saving treatment. On 1-25-2025 at 11:39 am V13 (R1 Family Member), said, (R1) was at the facility for about 2 weeks, on 12-31-2024 at about 8:30 pm I called R1's room without any answer, I then called the nurse station and asked the nurse to please take the portable phone to R1's room. I am glad I called because R1 was unresponsive when the nurse (V17) went into R1's room. On 1-25-2025 at 1:05 pm V17 (Registered Nurse) said, R1 was alert and oriented, continent of bowel and bladder, able to verbalize her needs and wants, and knew how to manage the LVAD. On 12-31-20224 at 8:30 pm, R1's son called and requested for the portable phone to be taken to R1's room, I went to R1's room and R1 had a change in condition, R1 was breathing uneasy, R1 did not use oxygen but her saturation was in the 80's. R1 was not responding to verbal or external rub. I immediately called for help, I checked the LVAD, the machine was wet with urine, the machine was in between R1's legs and everything in the bag was wet, another nurse, V19, changed the battery then R1 opened her eyes but was having difficulty breathing, I put R1 on some oxygen, and she was not responding as her normal base line. 911 came and assessed the patient and took the patient to the hospital, R1 was breathing and responding at that time. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1-25-2025 at 1:15 pm V19 (Licensed Practical Nurse) said, I was working on 12-31-2024, I remember that the nurse called for my help, R1 was not responding to verbal and tactile stimuli and she was breathing very slowly and she was slanted over to the front while in bed, I quickly replaced the battery and R1 started breathing and moving again, we did not know how long the machine was not working. No alarms were going off because the machine was totally off. 911 came to take the patient to the hospital. On 1-25-2025 at 1:27 pm V18 (Nurse Practitioner) I know R1, If the LVDA is not on the patient can become unresponsive, I was not aware that the machine got wet, this is the first time I heard that, I cannot confirm that the machine will turn off if it gets wet or not. On 1-25-2025 at 2:45PM V15 (Registered Nurse/ ADON) said R1, came with LVAD alert oriented X4, continent of bowel and bladder. R1 had experience caring for the assisted device at home. On 12-31-2024 I was informed by V16 (Nursing supervisor) that R1 was sent out via 911 to the hospital because the LVAD was malfunctioning. On 1-25-2025 at 2:20 pm V2 (Director of Nursing) said, we do not have any policy to care for patients with LVAD we have the manufacture recommendations that come from the hospital and the doctor's orders. The LVAD was not working because it was wet with urine, the LVAD needs to be dry at all times, R1 was able to change the batteries and manage the LVAD. V2 did not present any documentation on battery replacement. On 1-25-2025 at 4:15 pm V21 (Certified Nurse Assistant), said I worked on 12-31-2024, R1 was my patient, I gave her dinner tray to R1 at about 5:30 pm, and by 6:30 pm I gave R1 water and picked up her dinner tray. R1 was alert and oriented, continent of bowel and bladder, I assisted her to the bedside commode. R1's call light was within reach. At about 8:30 pm the charge nurse called me, I came to R1's room and saw that R1 was not looking well, the other nurses came and brought the emergency cart by the door, and they replaced the batteries in the cardiac bag that rests on R1's neck, they pulled out two batteries from the bag, as soon as they did that R1 started to take a deep breath and getting more alert, the paramedics came very shortly and took her to the hospital. On 1-25-2025 at 3:30 pm V1 (Administrator) presented Manufacture Guidelines titled: Heartmate 3 LVAD patient guide excellence in every moment. V1 said, on page 149: do not submerge the shower bag in water, the system controller must be kept dry at all times. On page 246 Submersion in water or liquid may cause the Left Ventricular Assist Device to stop. The reason for the LVAD was not functioning properly was because it was wet. On 1-26-2025 at 11:50 am V1 said, R1 was trained before coming here on how to monitor the LVAD, and how to change the batteries, R1 was admitted for wound management, not for LVAD management, R1 was able to manage the machine and the staff was assisting with the daily care to make sure the machine was working well and documented in the daily check form and also in the electronic medical record. We in service the nursing staff on care and management of the LVAD yearly and before R1 was admitted . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1-26-2025 at 1:00 pm V20 (Cardiologist) said, I had a nurse practitioner that was following R1 weekly. I have worked with LVAD for over [AGE] years, I am not aware of any function built in to shut off the LVAD if is exposed to moisture, I had never seen that before. The patients that have the LVAD are patients that can care for the device independently, but I will expect the staff to help R1 to manage the care of the LVDA at all times including replacing batteries and making sure the device is working well. According to hospital #1 record dated 12-31-2024 R1 arrived at the emergency room at 9:33 pm, (R1) presented with unresponsiveness. Per long-term care report at 8:30 pm R1 was less responsive LVAD was not working, the battery was changed and the LVAD turned on. Per emergency medical services (EMS): R1 was found unresponsive, with no LVAD alarms. Battery changed on the LVAD and R1 slowly became more responsive. R1's admitting diagnosis to the emergency room was a complication involving the left ventricular assist device (LVAD). Per hospital #1 record on 12-31-2024 at 11:12 pm while R1 was in the emergency room the cardiology team ran a diagnostic (interrogation) of the LVAD with results as follows: at 6:50 pm low voltage, 9:40 pm pump completely off. R1 will be transferred to another local hospital #2 for a higher level of care and further management of the LVAD. According to manufacturer guidelines, low voltage is considered a Hazard Alarms occuring for conditions that are potentially life-threatening for the patient, the alarm will provide 15 minutes remaining of power. Hazard alarms require immediate attention. Hazard alarms flash and appear as black text on a red banner. On-screen messages for hazard alarms are accompanied by a continuous audio tone from the System Controller. 1. Daily Safety Check: Perform System Controller self test. When using a new power source, inspect System Controller power cable connectors for dirt, grease, or damage. When changing power sources, inspect connectors on battery clips for dirt, grease, or damage. When switching from the battery power to the Power Module or the Mobile Power Unit, inspect the connector pins and sockets for dirt, grease, or damage. Ensure that the Modular inline Connector is secure and the connector locking nut is in the locked position. Ensure no yellow indicator is seen under the inline locking nut. Perform a Power Module self test. Maintain the Power Module connection to the AC power source. If not properly monitored, the internal battery drains, causing potential damage. Manage the Driveline exit site in accordance with the instructions provided by the clinician. Inspect the Driveline exit site for signs of infection, including redness, tenderness, swelling, discharge, or a foul odor. Use sterile technique to touch or handle the exit site. 2. Weekly Safety Check, Clean the metal battery terminals and contacts inside the battery clips. Inspect the Power Module or Mobile Power Unit power cord, used to connect the Power Module to the AC electrical outlet, for damage or wear. Ensure that the cord is not kinked, split, cut, cracked, or frayed. Do not use the cord if it shows signs of damage. Obtain a replacement, if needed. Manage the Driveline exit site in accordance with the instructions provided by the clinician. Inspect the Power Module patient cable or Mobile Power Unit patient cable, used to connect the System Controller to the Power Module or the Mobile Power Unit, for damage or wear. Ensure that the cable is not kinked, split, cut, cracked, or frayed. Do not use the Power Module patient cable or the Mobile Power Unit patient cable if it shows signs of damage. Inspect the HeartMate Shower Bag for damage or wear. Replace any equipment component that appears damaged or worn.