STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145304	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Riverwoods	3705 Deerfield Road Riverwoods, IL 60015

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to offer and perform care plan conferences for 1 resident (R26) reviewed for care plans in the sample of 30. The findings include: R26's electronic face sheet printed on 7/25/24 showed R26 has diagnoses including but not limited to chronic embolism and thrombosis of left femoral vein, peripheral vascular disease, alcoholic cirrhosis of liver, morbid obesity, and dementia without behavior. R26's facility assessment dated [DATE] showed R26 has no cognitive impairment. On 7/24/24 at 10:23AM, R26 stated, I have only had 1 care plan meeting within the past year and it was mainly about physical therapy. I would like to have regular meetings to discuss my care. Surveyor requested all of R26's care plan conference meeting summaries for the past year and the facility provided 1 document titled, IDT (Interdisciplinary Team) Care Conference Summary dated 11/10/23 and both R26 and his mother attended the conference. On 7/25/24 at 9:48AM, V17 (social services) stated, (R26's) last care plan meeting was 11/10/23. He attends his meetings with his mother. Currently, the only concerns are that he has a lot of extra items in his room. Care plan meetings are held every 3 months for all residents and they are invited as well as their power of attorney/guardian. I usually ask (R26's) mother if she wants one and the last time she said she didn't need one right now. (R26) has a surrogate decision maker who is his mother so she decides everything for him. When the time came to have a meeting I asked them both and they didn't want a meeting from what I remember. I didn't document it anywhere. I kept asking him but I never documented it so I can't show you anywhere that I offered the meeting. We didn't meet as a team to discuss his care either. I'm not sure if that's a problem or not. On 7/25/24 at 1:00PM, V2 (Director of Nursing) stated, We are in communication with (R26) and his mother frequently. I know I have offered a care plan meeting to both of them but I don't see where I documented the conversations. We haven't met as an IDT to discuss his care in a long time. I didn't realize we still needed to meet even when the resident and family declined to meet. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Comprehensive Care Plan dated 11-17-17 showed, Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being .The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly .

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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 0684 Level of Harm - Minimal harm or potential for 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** 20042 Based on observation, interview, and record review the facility failed to ensure a resident's heels were offloaded and failed to identify a wound to a resident's heel for 1 of 4 residents (R8) reviewed for wounds in the sample of 30. The findings include: On 7/23/24 at 10:41 AM, R8 was laying on her right side in bed with her left heel laying on her bed and her right heel laying on a pillow. R8 had offloading boots sitting in the window of her room. V3 CNA (Certified Nursing Assistant) was asked to come inside R8's room. V3 lifted R8's right heel up and there was a dressing in place. V3 lifted R8's left heel up, a black area was present to her heel. R8's skin to her left foot was dry and cracked with large flakes of skin present. V3 stated she was not aware of the area to R8's left heel. V3 stated R8's heels were to be elevated off the mattress when she is in bed. V3 was asked to check with the nurse to see if she was aware of the discoloration to R8's left heel. At 10:51 AM, V3 came back to R8's room and stated the wound nurse was going to check and see if anyone knew about the area to R8's left heel. V4 RN (Registered Nurse/Wound Care Director) came into R8's room and stated they are doing a preventative dressing to R8's right heel that is changed every 3 days. V4 stated she was not aware of any problem to R8's left heel. V4 stated there is dry eschar present to R8's left heel. V4 stated she V8 should have the offloading boots on for prevention. V4 stated staff are to let her or the primary nurse know immediately when there are changes to a resident's skin. The Wound assessment dated [DATE] at 11:20 AM for R8 showed a vascular wound to her left heel; tissue type - necrotic, firm, and adherent; 2 cm (centimeter) x 2 cm x unknown (L x W x D). The Care Plan initiated on 7/23/24 for R8 showed, R8 has an arterial wound to her left heel. Offload bony areas using pillows, foam wedges, and/or offloading devices. Offload heels using heel protecting devices. The Order Summary Report dated 7/24/24 for R8 showed an active order that started on 1/6/24 to offload heels with foam boots/pillows while in bed, every shift for prevention. The Face Sheet dated 7/24/24 for R8 showed diagnoses including stage 4 pressure ulcer of the sacral region, protein-calorie malnutrition, vascular dementia, hypertension, peripheral vascular disease, major depressive disorder, residual schizophrenia, anemia, osteoarthritis, and hyperlipidemia. The Care Plan initiated on 7/25/24 for R8 showed, R8 has a diagnosis of peripheral vascular disease. Keep skin on extremities well lubricated with lotion in order to prevent dry skin and cracking of the skin. Monitor for any signs and/or symptoms of skin problems related to peripheral vascular disease including redness, edema, blistering, itching, burning, bruises, cuts, other skin lesions. Monitor the extremities for, document and notify the physician of any signs and/or symptoms of injury, infection or ulcers. The MDS (Minimum Data Set) dated 5/29/24 for R8 showed moderate cognitive impairment; substantial/maximal assistance needed for rolling left and right; dependence for transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pressure Injury and Skin Assessment policy (1/17/18), Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform a detailed assessment. Care givers are responsible for promptly notifying the charge nurse of skin breakdown.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review the facility failed to identify pressure ulcers prior to becoming advanced stages for 2 residents (R47, R97). This failure resulted in R97 developing a stage 3 pressure ulcer. The facility failed to have preventative measures in place for a resident (R8) with a stage 4 pressure ulcer, failed to implement wound treatment for 2 residents (R26, R47), failed to provide pressure ulcer prevention measures for a resident (R35), failed to accurately assess a wound for 1 resident (R97), failed to assess a reopened, advanced stage pressure ulcer for 1 resident (R26). These failures apply to 5 of 9 residents reviewed for pressure ulcers in the sample of 30. The findings include: 1. R97's electronic face sheet printed on 7/25/24 showed R97 has diagnoses including but not limited to hypertensive chronic kidney disease, end stage renal disease, dependence on renal dialysis, type 2 diabetes, morbid obesity, peripheral vascular disease, and pressure ulcer of left buttock stage 3. R97's facility assessment dated [DATE] showed R97 has no pressure ulcer injuries. R97's skin risk assessment dated [DATE] showed R97 is at risk for skin breakdown. R97's Wound Assessment Details Report dated 7/16/24 showed, Trauma/Abrasion, facility acquired, left buttocks, 1x1x0cm (centimeters). R97's Wound Assessment Details Report dated 7/19/24 showed, Pressure Ulceration Stage 3, facility acquired, left buttocks, 1x2.3x0.2cm, light serosanguinous (thin, yellow/pink) drainage. On 7/25/24 at 1:18PM, V4 (Wound care nurse) stated, (R97's) pressure ulcer is new for her, it is not a reopened pressure ulcer. I wasn't the one who assessed her wound. The person who assessed it is no longer here. I don't think she really knew how to assess wounds very well. (R97) should have never developed a stage 3 pressure ulcer. She is very compliant with offloading and repositioning and gets her showers regularly so this definitely should have been identified prior to a stage 3. I know that she was having some loose stools for a bit but I can't even say that is an excuse for her developing the ulcer. Hers should have been identified prior to a stage 3 for sure. It was initially assessed as an abrasion which was incorrect. Once the wound physician saw (R97) it was correctly assessed and proper treatment was initiated. There is no way this was ever an abrasion. It is clearly on an area where there is pressure so it should have been assessed as that 'from the get go.' Skin assessments should be done during perineal care, dressing, bathing, etc. Anytime they are able to observe skin they should be checking it. Shower days are best days because they have a whole view of the resident's body. It is important to identify wounds early for the best chance to heal a wound. New wounds need to have treatment initiated immediately to prevent worsening or infection or delay. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's policy titled, Pressure Injury and Skin Condition assessment dated [DATE] showed, Purpose: To establish guidelines for assessing, monitoring, and documenting the present of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented .3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse .11. A wound assessment for each identified open area will be completed and will include .c. stage of pressure ulcer . 2. R26's electronic face sheet printed on 7/25/24 showed R26 has diagnoses including but not limited to chronic embolism and thrombosis of left femoral vein, peripheral vascular disease, alcoholic cirrhosis of liver, morbid obesity, and dementia without behaviors. R26's facility assessment dated [DATE] showed R26 has 1 stage 3 pressure injury. R26's physician's orders from (local wound center) dated 5/14/24 showed, Pressure injury posterior thigh and right buttock Stage 3 cleanse with normal saline, apply skin prep and Enluxtra, cover with mepilex border foam daily. R26's May 2024 physician's orders showed, 5/21/24 Wound care: right buttock-cleanse with normal saline, pat dry, apply Enluxtra/skin pep to peri-wound, cover with mepilex bordered foam dressing. (7 days after R26's wound physician ordered the treatment) R26's wound assessment dated [DATE] showed, Pressure ulceration stage 3, right buttock, facility acquired, 0.5x0.5cm with scant, serous (clear/yellow) drainage. (This assessment was completed 6 days after R26's wound reopened). On 7/25/24 at 1:18PM, V4 (wound care nurse) stated, (R26) has 2 pressure wounds- 1 is on his posterior right thigh and 1 on his right buttock. He doesn't follow recommendations, and these are both ongoing pressure wounds. His right buttock has healed and reopened. Staging for a reopened wound has to be staged as it was before. His was a stage 3 and reopened so we had to stage it as a stage 3. The nurse that received the orders and assessment from the wound center should have notified the wound team right away when his buttocks was determine to have reopened so that we could do an assessment and implement orders. 38488 3. R47's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include hypertensive chronic kidney disease, dementia with behavioral disturbance, generalized osteoarthritis, osteoporosis, hyperlipidemia, and peripheral vascular disease. R47's facility assessment dated [DATE] showed she has severe cognitive impairment and is dependent on staff for all cares. R47's care plan initiated 12/31/24 showed, [R47] has pressure injury to sacrum, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to: Dementia, Chronic Kidney Disease, Hypertensive Chronic Kidney Disease, bradycardia, generalized osteoarthritis, osteoporosis . contractures, fragile skin, immobility, incontinence of bowel, and incontinence of urine . Interventions . Treatments as ordered by provider . R47's initial wound assessment dated [DATE] showed a facility acquired stage 3 pressure ulcer to R47's sacrum measuring 1.5 cm x 1.0 cm x 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R47's December 2023 eTAR (electronic Treatment Administration Record) showed an order started 12/31/23 showed Wound Treatment to Sacrum; cleanse area with normal saline pat dry and apply medihoney and cover with foam dressing every 24 hours as needed. This order was not documented as completed on 12/31/23 on the December 2023 eTAR. R47's January 2024 eTAR showed a new order dated 1/5/24 for Wound Treatment to Sacrum; cleanse area with normal saline, pat dry and apply medihoney and cover with foam dressing every day shift for wound care. There was no evidence of dressing changes being completed for R47's sacral wound from 1/1/24 through 1/4/24. On 7/25/24 at 11:12 AM, V2 DON (Director of Nursing) said to identify new skin issues the staff should be doing skin assessments with all cares such as incontinence care, showers, and activities of daily living. On 7/25/24 at 2:10 PM, V4 RN (Registered Nurse) said it is important to identify wounds quickly and get interventions and treatments added immediately so the wound does not get worse. 20042 4. On 7/24/24 at 7:58 AM, R8 was sitting up in bed, with the head of her bed at 90 degrees. R8 had an over the bed tray table in front of her. At 8:50 AM and 11:54 AM, R8 was sitting up in bed with her head of the bed at 90 degrees. There weren't any positioning devices in place. At 11:54 AM, R8 was asked if anyone had turned her or repositioned her in bed today and she replied, No. At 12:56 PM, R8 will in the same position she was in at 7:58 AM, 8:50 AM, and 11:54 AM. R8's alert and oriented roommate (R27) stated no one had been in to reposition R8 all morning. On 7/24/24 at 2:11 PM, V4 RN (Registered Nurse/Wound Care Director) stated R8 has a pressure ulcer to her sacrum and should be repositioned every two hours. The Wound Assessment Details Report dated 7/19/24 for R8 showed she has a stage 4 pressure ulcer to the sacrum that is 1 cm x 4 cm x 1.50 cm (L x W x D). R8's Care Plan dated 5/29/24 showed, R8 has a pressure injury to her sacrum Foam wedges for proper offloading. Turn and position the resident per physician's orders. The MDS (Minimum Data Set) dated 5/29/24 for R8 showed moderate cognitive impairment; substantial/maximal assistance needed for rolling left and right; dependence for transfers. The facility's Pressure Ulcer Prevention (1/15/18) showed, turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. 5. On 7/24/24 at 8:48 AM, R35 was dressed and sitting in her wheelchair in her room with a tray table in front of her. R35 had a thin pressure relief cushion in place to her wheelchair. The cushion did not come to the front edge of wheelchair seat; the cushion was approximately 1 inch back from the edge. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/24/24 at 12:00 PM, R35 was sitting in her wheelchair at the dining room table for lunch. R35 had a thin pressure relief cushion in place to her wheelchair. The cushion did not come to the front edge of wheelchair seat; the cushion was approximately 1 inch back from the edge. V20 (R35's daughter) was feeding R35 and stated, she has not been notified of any pressure ulcers. After lunch they will lay her down due to her pressure ulcers in the past. R35 usually gets pressure to her buttocks. V20 stated she would appreciate it if they would call her and let her know when R35 has a pressure ulcer. On 7/24/24 at 1:20 PM, V9 LPN (Licensed Practical Nurse/Wound Nurse) changed the dressing to R35's left buttock wound. There was scarring to R35's left buttock and a small, slit like opening to her left buttock. V9 stated the pressure ulcer was either a stage one or stage two and is open. V9 stated she would need to look in the computer for the stage of the pressure ulcer. V9 was shown the pressure relief cushion in R35's chair that was flattened, worn in appearance, and positioned approximately 1 inch back from the edge of the wheelchair. V9 measured the cushion and stated it was 4 cm thick. R35 stated the wheelchair cushion should come out to the edge of the chair and should be thicker. On 7/24/24 at 1:59 PM, V4 RN (Registered Nurse/Wound Care Director) stated for pressure relief cushions in wheelchairs the staff should be looking for signs of wear and replace the cushion. The cushion should fit the chair. The Wound Care Physician Note dated 7/18/24 for R35 showed, follow up left buttock wound - re-opened; stage 3 pressure; 0.5 cm x 1.2 cm x 0 cm; 100 % non granulating tissue with defined margins. Date reported - 7/18/24. Preventative measures in place - low air loss mattress, heel offloading being done, turning schedule present, wheelchair cushion. Assessment and Plan: Pressure ulcer of left buttock, stage 3. Clean with normal saline, apply medicated petroleum dressing and dry dressing. Plan of care: Upright incline limit to 30-45 degrees for prolonged period of time, when there is a risk for ischial pressure, unless patient can reposition. Wheelchair cushion or custom molding when sitting and re positioning as needed. Please limit wheelchair for maximum of 2 hours at a time. The Nurse Pressure Injury assessment dated [DATE] showed a left posterior stage 3 pressure ulcer that was first identified on 7/16/24 when bathing/showering. The Face Sheet dated 7/25/24 for R35 showed diagnoses including Parkinson's disease, hypertension, diabetes mellitus, hyperlipidemia, osteoarthritis, and hypothyroidism. The MDS (Minimum Data Set) dated 5/28/24 for R35 showed moderate cognitive impairment; dependence for transfers; and substantial/maximal assistance for rolling left and right.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 20042 Based on observation, interview, and record review the facility failed to check placement prior to starting feeding, failed to flush after tube feeding, and failed to ensure a resident received tube feeding as ordered for 2 of 2 residents (R43 & R125) reviewed for tube feeding in the sample of thirty. The findings include: 1. On 7/24/24 at 8:44 AM, R43 was not in her room; R43 was at dialysis. R43's opened tube feeding bottle was hanging on a pole with the tubing attached to the pump and the pump turned off. On 7/24/24 at 1:05 PM, R43 was back in her room, in her bed and the tube feeding was no longer hanging on the pole. V8 LPN (Licensed Practical Nurse) was out in the hallway at her medication cart. V8 stated, the order for her tube feeding is to turn it off at 12:00 PM. The night nurse gets her ready and off to dialysis. She was over at dialysis at 7 AM and did not have the tube feeding with her. I was questioning it myself; not sure why they don't change either her dialysis time or her tube feeding time around dialysis. It would make more sense to do do dialysis from noon to 4:00 PM. R43's tube feeding starts at 6:00 PM and is to run until 12:00 PM the next day. Tube feeding isn't given during dialysis. I know her tube feeding was not going while she was at dialysis today. The Order Listing Report for R43 dated 7/25/24 showed on 7/10/24 R43 had an order for tube feeding to infuse at 55 ml per hour for 18 hours from 6:00 PM to 12:00 PM. The order was revised on 7/24/24. After the interview with V8 LPN on 7/24/24 at 1:05 PM, the Order Summary for R43 showed a new order was entered at 3:00 PM changing the enteral feeding time to start at 12:00 PM and end at 6:00 AM for the tube feeding that provided a carbohydrate steady feeding with 0.08 gram-1.8 Kcal./ml liquid (55 ml /hr) x 18 hours. On 7/25/24 at 11:15 AM, V2 DON (Director of Nursing) stated she changed R43's orders yesterday so R43 would get the tube feeding around her dialysis schedule. The Dietary Note dated 7/8/24 for R43 showed, R43 had been receiving mixed nutrition orally and enterally but was change to nothing by mouth due to difficulties swallowing. R43's enteral feeding was increased to meet her needs. Tube feeding at 55 ml x 18 hours (990 ml total formula). Will coordinate care with dialysis. The Face Sheet dated 7/25/24 for R43 showed diagnoses including hypertensive chronic kidney disease, end stage renal disease, dependence on renal dialysis, gastrostomy, atherosclerotic heart disease, seizures, hyperlipidemia, functional quadriplegia, polyosteoarthitis, and peripheral vascular disease. The Care Plan dated 5/15/24 for R43 showed she requires enteral feeding Enteral feeding is related to pneumonia and diagnosis of dysphagia. Enteral nutrition per physician's order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Tube - Feeding and Care policy (8/3/20) showed, Methods of administration: continuous: Prescribed amount of formula volume is given over a specific period of time that is usually less than 24 hours. Licensed nurse will review physician's order for type of formula, concentration, rate of flow, and method of administration. 34891 2. R125's face sheet printed on 7/25/24 showed diagnoses including but not limited to cervical fracture, dysphagia (difficulty swallowing), and encounter for attention to gastrostomy (surgery to insert a tube through the abdominal wall and into the stomach for liquid nutrition). R125's July 2024 order summary report showed orders start dated 7/15/24 for NPO (nothing by mouth) and liquid nutritional formula four times a day at 355 milliliters via the gastrostomy tube. On 7/25/24 at 9:46 AM, V10 (Registered Nurse) administered R125's liquid nutrition via the gastrostomy tube (G-tube). V10 inserted the piston syringe into the end of the G-tube and flushed with 50 milliliters of water. V10 gave the 355 milliliters of liquid nutrition and closed the G-tube. V10 did not check for placement prior to administering the liquid nutrition and did not flush the tube after administration. V10 said he gives R125 his medications and liquid nutrition twice per shift, once in the morning and again at noon. On 7/25/24 at 12:21 PM, V2 (Director of Nurses) stated feeding tubes should be checked for proper placement prior to anything going into it. It is important to ensure it is the right place in the stomach. There is the potential for infection and improper infusion. The flushes are important to ensure the tube has nothing left in it and the full quantity of nutrition or medication is received. The facility's Gastrostomy Tube-Feeding and Care policy last revision dated 8/3/20 states under the bolus feeding section: 1. Check placement and residual .3. Administer the prescribed feeding .4. Flush tube with approximately 30 milliliters of water.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review, the facility failed to ensure narcotics for discharged residents were removed from the medication cart in 1 of 6 medication carts reviewed for the medication storage task. The findings include: On [DATE] at 10:22 AM, the far-west medication cart was reviewed with V11 (Registered Nurse-RN). In the narcotic box of the medication cart, two medication cards along with their reconciliation sheets were behind a box of tissues. V11 RN said the cards belonged to two residents that have been discharged from the facility. One medication card contained Tramadol (a narcotic used to treat moderate to severe pain) for R307. V11 said she thinks R307 was discharged about a week prior. The other medication card contained Morphine (a narcotic used to treat moderate to severe pain) 30 mg tablets for R308. V11 said R308 was discharged from the facility about a month prior. V11 said the medications for R307 and R308 should not be in the medication cart; they should have been given to V2 (Director of Nursing-DON) when R307 and R308 left the facility. On [DATE] at 12:28 PM, V2 (DON) said when a resident is discharged from the facility, the resident's medications should be discontinued. V2 said the facility's policy is to send the narcotics back to the pharmacy as soon as possible. If the pharmacy will not take the medications back, the pills should be destroyed. V2 said this should happen as soon as possible to eliminate any issues or risks. R307's Admission Record, provided by the facility on [DATE], showed he was admitted to the facility on [DATE] and discharged on [DATE]. R307's Order Summary Report, provided by the facility on [DATE], showed an order for Tramadol 50 mg (milligram) tablets. Give one tablet every six hours as needed for pain. The report showed another order for Tramadol 50 mg tablet. Give half a tablet every six hours as needed for moderate pain. The report also showed an order dated [DATE] for R307 to be discharge to home on [DATE]. R308's Admission Record, provided by the facility on [DATE], showed he was admitted to the facility on [DATE] and discharged on [DATE]. R308's Order Summary Report, provided by the facility on [DATE], showed an order for Morphine Sulfate ER extended release 30 mg tablet. Give one tablet at bedtime for pain/pain management. The report showed an order dated [DATE] to discharge R308 to home on [DATE]. The report also showed an order dated [DATE] to discontinue all current orders upon discharge or 24 hours after hospitalization . The facility's policy and procedure titled Medication Storage, with a revision date of [DATE], showed 15. Facility should ensure that medications and biologics for expired or discharged residents are stored separately, away from use, until destroyed or returned to the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145304	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Riverwoods	3705 Deerfield Road Riverwoods, IL 60015

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 41639 Based on interview and record review, the facility failed to offer snacks for 4 of 4 residents (R68,R98,R109, R130). This applies to 1 of 1 residents reviewed for HS (bedtime) snacks in the sample of 30 and 3 residents outside of the sample. The findings include: On 7/24/24 at 11:00AM, the resident council meeting was held on the main dining area. R68, R98, R109 and R130 were present in the meeting and stated they are not offered bedtime snacks. R130 stated if she goes and finds someone they will give her a snack but they are not routinely offered. All 4 residents stated they would like to be offered a snack before bed as they get hungry between dinner and breakfast. R68, R98, R109, and R130's facility assessments were reviewed and showed all residents have no cognitive impairment and no documentation was present in their chart regarding snacks being offered, refused, or accepted. On 7/24/24 at 12:45PM, V6 (Dietary Manager/Registered Dietician) stated, We provide snacks such as cookies, fresh fruit, sandwiches, and yogurt to all the units and they are to be passed out by the aides on each unit. Residents only get HS snack if they request them. We leave 10 -12 packages of snacks on each unit and when I check the trays there are maybe 1 or 2 packages gone. It's never all gone or even half of the items. On 7/25/24 at 1:00PM, V2 (Director of Nursing) stated, We have snacks available at all nurse's stations. The residents just have to ask for a snack and we will provide one for them. We do not go around and offer a snack nor do we document it. We don't need to monitor every single thing our resident's ingest. If they want a snack, they know where we keep them. The facility's policy titled, Fortified Foods, Supplements, and Snacks dated 2020 showed, d. Snacks: regular food items that are available on the units or can be specified to be served at designated times (such as HS for a diabetic) and generally not required to be ordered by the physician .9. The resident's acceptance and tolerance of fortified foods, med pass, and other supplements/snacks is monitored for resident tolerance and acceptance by the dining services manager and registered dietician. Acceptance observational data may be included in a progress note, care planning summary documentation, or by other members of the interdisciplinary team in designated locations in the medical record such as nursing or therapy notes .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure hairnets were worn correctly, failed to ensure staff were knowledgeable in the use of the dishwasher, and failed to ensure expired foods were destroyed. This applies to all residents residing in the facility. The findings include: The CMS 671 form dated [DATE] showed 153 residents residing in the facility. 1. On [DATE] at 10:35 AM, V13 (DA-Dietary Aide) was seated in the kitchen office wearing her hairnet only covering the bun on top of her head. At 11:41 AM, V13 was standing at the food service tray line and her hairnet was only on her top bun. At 1:01 PM, V13 tested the dishwasher sanitation level. The hairnet was only covering half of her head. On [DATE] at 1:35 PM, V13 was seated in the kitchen office and her hairnet was only covering her top bun. On [DATE] at 1:15 PM, V12 (Food Service Director/Registered Dietician) stated hairnets are require by everyone in the kitchen. They are important to prevent cross contamination. Hairnets keep hair out of resident food. Staff need to be sure their hair is fully covered to keep food safe. The facility's undated Hair Restraints policy states: 1. Staff shall wear hair restraints in all food production, dishwashing, and serving areas. 2. On [DATE] at 10:39 AM, V14 (DA-Dietary Aide) was operating the dishwasher and running coffee cups through it. V14 was asked how he knows if the dishwasher is sanitizing the dishes correctly. V14 pointed to a temperature dial at the front of the machine. V15 (DA) was called over and translated for V14. Both dietary aides explained the temperature dial is watched during use to be sure it reaches 100 degrees. A test tray was run and V14 pointed to the dial and showed it was at 100 degrees. The dietary aides said the temperature is recorded in the logbook to show the 100 degrees was reached. The aides said the machine is checked that way before every meal and all kitchen staff are responsible for doing it whenever they are assigned the dishwasher. The facility dishwasher log for [DATE] was reviewed and showed the entire month readings at exactly 100 for everyday and every mealtime. The log had an area at the top that read: Required PPM: (blank). Under the required PPM was: minimum 50 PPM. On [DATE] at 11:06 AM, V12 (Food Service Manager) stated he was unsure how the dishwasher sanitizes the dishes. V12 supplied a typed document that showed the dishwasher has three stages. The third stage rinses the dishes at temperatures between ,d+[DATE] degrees Fahrenheit to sanitize them at the high heat level. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:16 AM, V16 (DA) stated the dishwasher is tested using test strips that show the sanitizer solution level. V16 said the test strip changes to a dark purple to show the level. V16 ran a test load and used the strip to test the sanitizer level. The strip did not change color in anyway and read less than 10 ppm (parts per million). V16 did a second test and again the strip read less than 10 ppm. V16 said we will notify the maintenance staff right now to determine what is going wrong. On [DATE] at 11:35 AM, V21 (Maintenance) stated the hose into the sanitizer solution was not reaching down into the solution all the way. It was not sanitizing the dishes correctly. If it can't reach the solution, the dishes are not properly sanitized. It needs to test between 50 and 100 ppm to be sure it is working correctly. V21 clarified the machine was not a high temperature type machine and sanitized items using the chemical disinfectant type process. On [DATE] at 1:01 PM, V12 (Food Service Manager) said the dishwasher testing is done before every use. Staff need to use strips to see if the concentration is correct. It needs to test at 50 ppm or higher to be sure it is working correctly. The log should show the PPM and not the temperature. All kitchen staff need to know how to test it. Food borne illness is a big risk if dishes are not cleaned and sanitized the right way. The facility's undated Dishwashing: Machine Operation policy states:1. All dishwashing machines should be operated according to manufacturer recommendations (all items) should be cleaned and sanitized in either a high-temperature dishwashing machine .or a chemical-sanitizing dishwashing machine that uses a chemical sanitizing solution. 3. On [DATE] at 11:50 AM the walk-in refrigerator had a pan of cooked rice in it and the dating on the pan was not legible. A container of beef flavored base had a use by date of ,d+[DATE] written on it. A second one next to it did not have any date on it. Both containers were 90% used. The same refrigerator had three open, one-gallon containers of salad dressing in it. All three were open and without any type of use by date on them. On [DATE] at 12:05 PM, the dry storage room had several large bins of dry food items. A bin of a thickener had a use by date of by [DATE] and the flour use by date of [DATE]. The oatmeal had a prep date of , d+[DATE] and the use by date was blank. The sugar had a prep date of [DATE] and the use by date was blank. A bin of uncooked rice had no date on it at all. Bins of barley, lentils, and dry green split peas did not have any dates on them. On [DATE] at 1:07 PM, V12 (Food Service Manager) was shown the expired and undated food items. V12 said dates should be checked by staff on a daily basis. It is important to ensure the quality and high standards. Dates show the food is not spoiled or outdated. All expired foods should be thrown away. There is the potential for resident illness if expired food is used. Everything needs a use by or expiration date on it. The facility's undated Labeling and Dating Food (Date Marking) policy states: All foods stored will be properly labeled according to the following guidelines. Expiration dates on commercially prepared, dry storage food items will be followed. Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date.