STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

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 0689 Level of Harm - Minimal harm or potential for 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** 45002 Based on interview and record review, fthe acility failed to follow their policy to ensure safe mechanical lift transfers are practiced for one (R15) out of three residents in a sample of 15. Findings include: On 10/16/2024, at 2:14 PM, V20 (Restorative Nurse) stated he is familiar with R15. V20 stated he was on vacation during this time, and so the previous Director of Nursing should have investigated the fall incident. V20 stated R15 had a fall on 4/29/2024. V20 stated according to the progress note, they were trying to transfer R15 from the bed to the speciality chair. The next thing that is documented is the aide called for the nurse's attention because R15 was on the floor due to transferring to the dialysis chair. R15 fell in her room. R15 was being transferred from her bed to the speciality chair via mechanical lift and fell off the lift. V20 stated he doesn't know what exactly happened. V20 stated the staff members who were taking care of R15 that day were V21 (Registered Nurse) and V23 (Certified Nursing Assistant). V20 stated during the time of the fall, V22 (Former Director of Nursing) was the falls coordinator. V20 stated V22 did not complete an investigation of the fall. On 10/16/2024, at 10:47 AM, V2 (Director of Nursing) stated she wasn't the Director of Nursing when R15 fell . V2 stated V22 is not here anymore. V2 stated they do not have an investigation binder for R15's fall. V2 stated an investigation must definitely be done for any falls. On 10/16/2024, at 12:00 PM, V1 (Administrator) stated a reportable was not completed nor submitted to Illinois Department of Public Health when R15 fell off the mechanical lift in April. On 10/16/2024, at 3:04 PM, V23 (Certified Nursing Assistant) stated she has been working at the facility for past [AGE] years. V23 stated V23 normally works on the 3rd floor. V23 stated she is familiar with R15 and the fall she had. V23 stated she made a mistake. V23 stated she was transferring R15 to the speciality chair using the mechanical lift and she used the wrong lift pad. V23 stated she thought it would hold her, but lift pad didn't. R15 slipped out of it and fell to the floor. V23 stated she landed on her upper back. V23 stated she was the only person transferring her that day. V23 stated, You're supposed to have two people when using the mechanical lift. V23 stated she got suspended for 3 days. V23 stated V22 (former Director of Nursing) suspended her. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/2024, at 1:35 PM, V15 (House Nurse Practitioner) stated he kind of remembers R15. V15 stated she had a fall back on 4/29/24. V15 stated according to his note, she apparently fell off the mechanical lift. V15 stated, According to the x-ray by the hospital, the results stated age indeterminate fracture which means I cannot conclude that (R15's) fall resulted in fracture. If her x-ray says acute fracture, then I could conclude that her fracture was because of the fall, but that's not what the hospital x-ray says. When you are sitting on the mechanical lift, you are sitting upright. So, when she fell , I would have expected a hip, pelvis, or sacrum injury. I would not expect a T12 (Thoracic) injury. If I were the hospital, I would have done a CT (brain scan) to confirm. R15's progress note by V15 documented in part: 4/30, R15 fell yesterday afternoon while patient was being transferred via mechanical lift. R15 fell out of the mechanical lift onto the floor. Patient was transferred to outside hospital and has an fracture of T12/L1 (neck and back) of indeterminate age. The primary physician was notified and patient is moving all four extremities with LROM (limited range of motion). Will continue to monitor vital signs. There is no acute distress. R15's hospital record (4/29/2024) documents in part: Best visualized on the lateral view is apparent age indeterminate fracture deformities of T12 and L1. Facility's Manual Gait Belt and Mechanical Lifts policy (1/19/2018) documents in part: Mechanical lifting devices shall be used or any resident needing a two person assist. Mechanical Lift (Hoyer) completed with 2 caregivers.