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	06/07/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 40061 Based on interview, and record review, the facility failed to follow a resident's (R53) preference for a shower schedule for one out of a total sample of 34 residents. Findings include: R53's Care Plan documents R53 has an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility, generalized weakness and pain due to chronic pain, and rheumatoid arthritis (initiated 5/20/2019). Interventions initiated 5/20/2019 include to encourage R53 to participate to the fullest extent possible with each interact and praise all efforts at self-care. On 6/04/2024 at 10:15 AM, R53 was alert and oriented to person, place, and time. R53 wanted to change shower schedules to mornings. R53 stated R53 informed V29 (Assistant Social Services Director) about wanting to change the Friday evening shower to a morning shower months ago, but facility has not changed it. R53 showed surveyor text message from R53 to V29, dated 1/05/2024 11:11 AM. It documents: can they possibly change my shower from Friday night to Saturday mornings? I'm just curious, it would be so much better for me. I like to shower in the mornings. Response timed 12:32 PM documents V29 was headed to see R53. Additional text message from 5/31/2024 at 10:45 AM documents another request to change the Friday evening shower to a morning shower. On 6/04/2024 at 12:11 PM, V6 (Licensed Practical Nurse) stated the residents' shower schedules were in a binder at the nurses' station. Facility's Floor Shower Schedules for the morning and evening shifts document R53's scheduled showers were on Tuesday mornings and Friday evenings. Surveyor clarified if the Floor Shower Schedules were up to date - V6 stated yes. On 6/06/2024 at 8:43 AM, V29 (Assistant Social Service Director) confirmed the phone number R53 had for V29. V29 stated R53 asked to change shower schedules Maybe two [Directors of Nursing] ago. V29 stated it was sometime at the end of last year. V29 stated, It wasn't set in stone. Facility's Bathing - Shower and Tub Bath policy, last revised 1/31/18, documents: A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or requested. (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: 145484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Resident Rights policy, dated 8/23/17, documents in part: Exercising rights means that resident have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

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F 0568

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50057

Based on interview and record review, facility failed to maintain resident personal fund accounting for five residents (R4, R22, R55, R138, R218) out of a sample of six residents (R4, R22, R55, R74, R138, R218).

Findings Include:

On [DATE] at 11 AM during Resident Council interview, R4 stated she used to get money each month, but now gets no money. R121 stated, Everyone has brought the money issue up. I feel entitled to money that I don't get. I get nothing. I spoke to the office. They said 'Well, maybe later, maybe next year'. R121 stated many residents have raised the issue of money and allowances. It comes up all the time. There has been no response from administration. R74 stated he feels that he is owed money that he is not getting. R121 stated the subject of money and allowances is a very horrible subject for people here. R121 stated, At least half of the residents here will tell you that they know that they are entitled to money, but can't get it. They go every month and ask. Some residents get money, and some residents feel that they should get money and they don't.

On [DATE] at 2 PM, V38 (Financial Coordinator) stated when a resident arrives at the facility, V38 meets with the resident. V38 asks the resident if they are going to be admitted short-term or long-term. If the resident expects to be at the facility long-term, V38 asks if the resident is going to receive any money. V38 then explains to the resident if they get Social Security benefits or a pension, the income comes to the facility, minus the allotted amount, and if they get Supplemental Security Income (SSI), the amount will be reduced once the Social Security Administration (SSA) knows the resident is in a long-term care facility. V38 then completes paperwork and advises SSA. V38 stated she sends in to SSA the 787 form, SS11 form, Nursing home report, and that provides SSA the information that they need to determine if they have a payee, and how the resident will receive their money. If the resident wants the money to come to the facility, the forms get submitted. If the resident does not want their income to go to the facility, V38 stated she asks the resident how they will pay the facility. Some residents have family pay or send a cashier's check. If the resident agrees that the facility will be the resident's financial representative, V38 signs the resident up for the facility's Resident Fund Management Services (RFMS) which tracks the resident's allowance. V38 stated, We become the representative payee. SSA sends us the check and a trust fund is developed. Residents get $30 a month for their personal use. V38 provided the Trial Balance document, which lists each resident who the facility is maintaining funds for.

On [DATE] at 2:30 PM, V38 (Financial Coordinator) provided response to request by surveyor for the status of 5 sampled residents (R4, R22, R55, R74, R 138). Two residents (R4, R74) raised concern about personal funds at the Resident Council interview. Three residents were from the list titled Trial Balance that was provided by V38. V38 stated R4's income stopped coming to the facility approximately two years ago. R4 was admitted to the facility on [DATE]. V38 stated she spoke to a Social Security representative on [DATE], who told V38 to send in documents to the agency so R4 could be interviewed.

(continued on next page)

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:30 PM, V38 (Financial Coordinator) stated R47 does not have a case on file at the facility. V38 stated V38 and R74 called Social Security last week on [DATE] to see why income was not being received, and a letter will be mailed in for an interview. R47 was admitted to the facility on [DATE]. On [DATE] at 2:30 PM, V38 (Financial Coordinator) stated R22's income is in suspension. V38 stated she spoke to Social Security on [DATE], and was instructed to send over nursing home report to receive a call for an interview. R22 was admitted to the facility on [DATE]. On [DATE] at 2:30 PM, V38 (Financial Coordinator) stated R55's income is in suspension. V38 stated she spoke to Social Security, who stated their records indicated R55 expired (died) in ,d+[DATE]. V38 stated she faxed documents to the Social Security office, and took R55 to the Social Security office. V38 stated she is now waiting for SSA to request medical records to get income restarted for R55. R55 was admitted to the facility on [DATE]. On [DATE] at 2:30 PM, V38 (Financial Coordinator) stated R138 was at a sister facility before coming to this facility. V38 stated she was told by the sister facility R138's income was zero. V38 spoke to V40 (Sister of R138), who informed V38 that R138 receives a pension, but V40 does not know where that money is going. V38 stated V40 believed that the prior facility was receiving R138's pension money. On [DATE] at 11:52 AM, V38 (Financial Coordinator) was interviewed and stated, (R74) never had income. Medicaid does not send a stipend or allowance. V38 stated when V38 began work at the facility, the previous Social Services Department Director helped residents to apply for benefits. V38 stated R74 came to V38 last week, and V38 called Social Services Administration on R74's behalf. V38 stated R4 asked her for help with her income and allowance. V38 stated she communicated with Social Services Administration, but I didn't document it. V38 stated, I don't know why (R4's) funds were stopped. (R4) used to get an allowance, but that stopped. V38 stated R138 was at a sister facility of the facility. V38 state she spoke to V40 (Sister of R138). V40 told V38 that R138 used to work for a government agency So she should have funds, but we don't have any information. V38 stated, I remember calling for some of the residents, but I didn't document those calls or communication. I know. If it wasn't documented, it wasn't done. I submitted forms yesterday. I will get you copies. On [DATE] at 12:15 PM, V8 (Director of Social Services) stated, We have no role in residents' funds, applying for Social Security benefits or disability benefits. That is the Business office. V8 described the Business Office as V38 (Financial Coordinator). V8 stated, (V38) handles all of that. On [DATE] at 2:30 PM, V38 (Financial Coordinator) was asked for the copy of documents V38 said she submitted. V38 stated, I have not sent any documents about finances for the five residents that we have discussed earlier. The Resident Funds policy, effective [DATE] and last revised [DATE], documented: Guidelines: This facility manages the personal funds of residents when such request is made by the resident. Residents' Rights for People in Long Term Care Facilities was reviewed and stated in part: (continued on next page)

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	145484	A. Building B. Wing	06/07/2024

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Your Rights Regarding Your Money: If you ask your facility to manager your personal money for you, it must do so (Medicare and Medicaid certified facilities only).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on observation, interview, and record review, facility failed to follow facility policy and standards of professional practice in documenting the code status of two residents (R31, R138); failed to educate one resident (R138) on Advanced Directives; and failed to engage the healthcare representative in the care of one resident (R138) out of 34 total residents in the sample. Findings: 1. On [DATE] at 11:08 AM, a POLST form (Provider Orders for Life-Sustaining Treatment) for R138, dated [DATE], stated, No CPR (Cardiopulomonary Resuscitation): Do not attempt resuscitation (DNAR) and Selective treatment: Primary goal is treating medical conditions with limited medical measures. Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP (Continuous Positive Airway Pressure) and BIPAP (Bi-level Positive Airway Pressure). May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated. On [DATE] at 12 PM, review of R138's medical record included an order for POLST A: Do not attempt resuscitation/DNR entered by V20 (Licensed Practial Nurse/LPN) on [DATE] and signed by V46 (Physician) on [DATE]. On [DATE] at 10:31 AM, V8 (Director of Social Services) stated, When residents are admitted to the facility, a Social Worker visits the resident. The Social Worker asks the resident if they have an Advanced Directive. If the resident has an Advanced Directive, the Social Worker asks for a copy. Once the Social Worker has a copy, the Social Worker lets nursing know, and the Social Worker uploads the Advanced Directive into the electronic health record. Social Services then updates the resident's care plan and tells nursing to change the code status based on what the Advanced Directive says. Nurses enter the Advanced Directive order. If the resident does not have an Advanced Directive, they are a full code status and remain a full code unless that status changes. V8 stated a POLST is an Advanced Directive. V8 stated if the resident has checked selective treatment in section B of the POLST form, that would be entered into the electronic medical record by Nursing. If the resident wishes to have a Power of Attorney or Advanced Directive, the resident comes to the Social Worker or Social Services Department. The healthcare representative is determined if the resident is alert and oriented and the resident can appoint an individual. Often, the family will step up to be the decision-maker. If there is no friend or family to be the healthcare representative ,if the resident cannot make decisions, the facility will petition for guardianship. If a resident is alert/oriented but can't communicate by speaking or writing, the Social Worker will question whether the resident is decisional. If the resident cannot communicate, Social Services would appoint a surrogate decision maker. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:15 PM, V2 (Director of Nursing) described if a resident comes in with a complete POLST form and the facility has a copy, nursing enters the DNR order into the EMR (electronic medical record). V2 stated nurses do not talk to the provider before entering the order. The nurse uses the order set in the electronic health record to enter the order. V2 looked at R138's POLST form and Advanced Directive orders in the electronic health record. The order entered is for DNR. When surveyor asked why selective treatment was not included with the Advanced Directive order entry, V2 stated, The resident has to be in hospice if the nurse selects comfort care. If the nurse selected selective treatment, it is the same as comfort care. V2 stated, DNR is no resuscitation. That is the direction of this patient. On [DATE] at 8:28 AM, V20 (LPN) stated,When a resident is admitted with a 'Do Not Resuscitate', it is put into the computer. Surveyor clarified that we were talking about the POLST form, and V20 stated that it is called a Do Not Resuscitate form. V20 stated the POLST documentation, It is the first thing that we put into the computer. If we don't have the document, the resident is a full code until we get the POLST form. V20 stated, Most POLST forms are DNR or full code and we enter either one of those orders in the computer. Surveyor and V20 then reviewed the POLST for R138. V20 stated based on the POLST, POLST B: Selective Treatment would be entered in the computer. V20 then reviewed the order for POLST A: Do not resuscitate. V20 stated, I entered POLST A: DNR because it is the first thing on the POLST form. If selective treatment is the first thing checked on the form, then I would have entered that. V20 stated, If a resident codes, we don't start anything until we look at the POLST Form. On [DATE] at 8:55 AM, V2 (Director of Nursing) stated if the POLST form stated in section A No CPR, and in section B Selective Treatment: primary goal is treating medication conditions with limited medical measures, the nurse would enter an order for POLST A: DNR. V2 stated the nursing process if a resident goes into cardiac arrest is to first look at the facility DNR list, and then to look at the medical record and the banner bar for the code status. The nurse then prints the POLST for specific instructions. If the code status is DNR in section one of the POLST Form, V2 stated, I can't resuscitate. The nurse would call the doctor, say that there is a change in condition, and say that the resident is a DNR. If the doctor had any instructions, the nurse would then follow the instructions. V2 looked at the POLST form for R138 and stated, It clearly says Do Not Resuscitate. On [DATE] at 9:56 AM, V43 (Nurse Consultant) stated if a resident presents a POLST which stated in Section A: do not resuscitate and in section B: selective treatment; both POLST A: DNR and POLST B: Selective Treatment is to be entered into the EMR. V43 stated, We have already begun auditing charts and working to fix this. 2. On [DATE] at 11:21 AM, R31's Provider Orders for Life-Sustaining Treatment (POLST) form, dated [DATE], documented: No CPR - do not attempt resuscitation (DNAR). Comfort-focused treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. On [DATE] at 11:23 AM, R31's medical record was reviewed. On [DATE], R31 had medical orders placed for may admit under hospice and POLST A: DNR comfort care. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:26 AM, R31's progress notes in the electronic health record were reviewed. the progress note by V41 (Nurse Practitioner), dated [DATE] at 11:32 AM, stated Code: Full. The progress note by V41, dated [DATE] at 13:38, stated Code: Full. The progress note by V41, dated [DATE] at 12:04 PM, stated Code: Full. The progress note by V41, dated [DATE] at 11:30 AM, stated Code: Full. The progress note by V41, dated [DATE] at 15:00, stated Code: Full. The progress note by V41, dated [DATE] at 13:10, stated Code: Full. The progress note by V41, dated [DATE] at 11 AM, stated Code: Full. On [DATE] at 1:13 PM, V41 (Nurse Practitioner) described R31's code status as, (R31) is in hospice care and has a DNR (Do Not Resuscitate) and comfort care. When V41's progress notes were read by V41, V41 stated, Oh sh**. I haven't changed it. V41 stated the accuracy of V41's documentation is important because if someone read my notes, they would code her. The Advance Directive Policy, effective [DATE] and was revised last on [DATE], was reviewed and stated: Purpose: To ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. Guideline: 1. At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law. 2. The social services and/or admissions director will be responsible for providing copies of state statutes, regulations, and information regarding advanced directives to resident, legal representative upon admission and also to families who wish to receive such information and assistance regarding advance directives and decisions regarding life sustaining measures and in no event shall give legal advise on the need of medical care directives. 4. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with state law.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on interview and record review, the facility failed to refer a resident to the appropriate state designated authority for re-screening and Level II referral after admission extended beyond initial 30 days. This failure has the potential to effect one resident (R55) out of 2 residents reviewed for PASARR in a total sample of 34. Findings include: R55 admitted to the facility [DATE]. R55's diagnosis includes but not limited to Anxiety Disorder, Schizoaffective Disorder, and Borderline Personality Disorder. R55's Order Summary Report, dated [DATE], documents: Lithium Carbonate Capsule 300 mg give 1 capsule by mouth one time a day for antipsychotics/antimanic agents ordered date [DATE], Mirtazapine Tablet 15 mg give 1 tablet by mouth one time a day for antidepressants, Olanzapine Tablet 5 mg give 1 tablet by mouth one time a day for antipsychotics/antimanic agents related to Schizoaffective Disorder, Sertraline HCl Tablet 50 mg give 1 tablet by mouth one time a day for antidepressant, Trazodone HCl Tablet 50 mg give 1 tablet by mouth one time a day for antidepressant. R55's Notice of PASRR (Pre-Admission Screening and Resident Review) Level I Screen Outcome, completed [DATE], documents: Exempted Hospital Discharge 30 Day Approval - a 30 day or less stay in the nursing facility is authorized. Re-screening must occur by or before the 30th day if the individual is expected to remain in the nursing facility beyond the authorization time frame. As the individual was medically admitted and is currently psychiatrically stable, they meet criteria for a 30 EHD (Exempted Hospital Discharge) approval. Should their stay require more than the 30 days, or they have an increase in mental health symptoms, please submit a Conclusion of a Time Limited approval Level I and a Level II referral will be initiated. On [DATE] at 9:57 AM, V8 (Social Service Director) stated, PASRR level I screenings are completed prior to admission to the facility as part of the pre-admission process, and depending on the resident's diagnosis and behaviors, a level II evaluation may be needed. V8 reviewed R55's PASRR level I screen and stated, It was Exempted Hospital Discharge and admission to the skilled nursing facility was approved for 30 days with suspected/confirmed PASRR conditions including mental health disability. Ig R55 stays in the facility longer than 30 days, then a level II assessment is required based on the PASRR level I screening completed prior to admission. V8 looked up R55 in the Maximus Assessment Pro System and stated, It shows the level I screen completed [DATE]. I cannot find that a level II assessment was done. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:07 AM, V30 (Social Service Consultant) stated PASRR level II screen determines if any specialized services are needed in the facility for someone with severe mental illness. V30 stated, (Agency) completed a Screening Verification form for (R55) on [DATE], which indicates nursing facility services are appropriate, however, it does not specify if specialized mental health treatment services are needed. V30 stated determining specific services for R55's mental health needs would only be done with the PASRR level II evaluation. V30 stated R55's diagnosis includes SAD (Schizoaffective Disorder), and Anxiety which are considered to be mental health illnesses. V30 stated, It looks like (R55) was approved to be in skilled nursing facility for 30 days from initial admitted , and after the 30 days a resubmission for review should have been ordered. V30 stated, Honestly, I do not see this resubmission, but we can submit the request right now. On [DATE] at 10:48 AM, V30 provided copy of request submitted on [DATE] at 10:30 AM by V30 to (company) which documents for screening due to previous PASRR short term approval for nursing facility stay is expiring or has expired. Facility provide document titled, Pre-Admission Screening and Resident Review (PASRR) documents, in accordance with Illinois regulatory standards and recommended practices this organization requires Level 1 and Level 2 pre-admission screening when applicable.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observations, interview, and record review, the facility failed to follow the residents comprehensive care plans to ensure communication boards/books were readily accessible at all times for 4 (R30, R63, R49, R71) out of 4 residents who speak foreign language in a final sample of 34. Findings include: 1. R30's clinical records show a re-admitted [DATE]. R30's Minimum Data Set (MDS), dated [DATE], shows R30 has the ability to understand others and has the ability to express ideas and wants. R30's communication care plan, initiated on 8/04/20, shows R30 speaks Spanish and has communication book near bedside. One intervention reads, Help [R30] acquire and learn to use appropriate device(s). On 6/04/24 at 10:01 AM, R30 was resting in bed alert and verbally responsive. Surveyor attempted to interview R30, but R30 started talking in a different language. R30 stated, Only Spanish. Surveyor could not find any type of communication board or binder in R30's room to communicate with R30. 2. R63's clinical records show a re-admitted [DATE]. R63's MDS, dated [DATE], shows R63 has the ability to understand others and has the ability to express ideas and wants. R63's communication care plan, initiated on 12/08/21, shows R63's primary language is Spanish and one intervention reads, Utilize appropriate augmentative devices, i.e., communication board/flash cards, multi-language dictionary, paper/cared with commonly used items/phrases writing pad, etc. Help me acquire and learn to use appropriate device(s). At 10:04 AM, R63's was up in a chair in R63's room, alert and verbally responsive. R63 stated R63 only understands and speaks little English. Surveyor asked if R63 has communication board to use to communicate in English, but R63 was unable to understand. Surveyor could not find any type of communication board or binder in R63's room to communicate with R63. 3. R49's clinical records show a re-admitted [DATE]. R49's MDS, dated [DATE], shows R49 has the ability to understand others and has the ability to express ideas and wants. R49's communication care plan, initiated on 9/03/19, shows R49's primary language is Spanish and one intervention reads, Utilize appropriate devices to help aid in the translation, such as: communication board/flash cards, multi-language dictionary, paper/card with commonly used items/phrases. At 10:53 AM, R49 was up in a wheelchair in R49's room, alert and verbally responsive. Surveyor attempted to conduct an interview with R49, but R49 was unable to understand English. No communication board or binder found in R49's room to assist R49 with communication. 4. R71's clinical records show an admitted [DATE]. R71's MDS, dated [DATE], shows R71 has the ability to understand others and has the ability to express ideas and wants. R71's communication care plan, initiated on 11/20/21, shows R71 primarily speaks Spanish with on intervention that reads, Utilize appropriate augmentative devices, i.e., communication board/flash cards, multi-language dictionary, paper/cared with commonly used items/phrases writing pad, etc. Help me acquire and learn to use appropriate device(s). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Elevate Care Chicago North		STREET ADDRESS, CITY, STATE, ZIP CODE 2451 West Touhy Avenue Chicago, IL 60645	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:57 AM, R71 was up in a wheelchair in R71's room alert and verbally responsive. Surveyor attempted to conduct an interview with R71, but R71 was unable to understand. R71 stated, Spanish. Surveyor searched for any communication board or binder to use to communicate with R71 but was unable to find. On 6/04/24 at 10:31 AM, V13 (Registered Nurse) stated V13 has residents that cannot speak and understand English. V13 stated R63's, R49's, R30's, and R71's primary language is Spanish and they should have communication boards at their bedside to assist them with communicating with staff and visitors. On 6/04/2024 at 2:04 PM, V7 (Director of Life Enrichment and Director Guest Relations) stated the Activity Aides complete the residents' assessments on language barriers. V7 stated the resident's communication assessment is done on admission and re-admission. V7 stated there are communication boards that should be accessible in the resident's room if needed. On 6/04/2024 at 2:15 PM, V8 (Social Service Director) stated, The Social Service Department provides communication boards and communication binders for the residents, and they are supposed to be easily accessible in the residents' rooms at all times to assist with communication. SSD care plan the communication and it's updated annually and quarterly. The facility's policy titled; Language Assistance Services with no date documents: It is the policy of this facility to offer language assistance services to all residents who are determined to have a language or communication barrier.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to follow their policy and procedure and the comprehensive care plan to ensure incontinence care was provided for a dependent incontinent resident in a timely manner for 1 (R2) of 2 residents reviewed for ADL (Activities of Daily Living) care in a final sample of 34. Findings Include: R2's clinical records show R2 has diagnoses not limited to Hemiplegia Affecting Right Dominant Side, Right Hand Contracture, and Vascular Dementia. R2's Minimum Data Set, dated dated [DATE], shows R2 is moderately impaired with cognition and require substantial/maximal assistance from staff with toileting. R2's comprehensive care plan shows R2 is incontinent of bowel and bladder with one intervention that reads: Provide pericare [perineal care] after each incontinent episode. On 6/04/24 at 10:16 AM, R2's room was noted with a strong urine odor. R2's was lying in bed alert and able to verbalize needs. R2 was still wearing a night gown, and R2's incontinence pad was soaking wet. R2 stated R2 moved his bowels and has been waiting for hours for the staff to clean R2. R2 stated R2 pressed the call light for assistance, but nobody came. On 6/04/24 at 10:27 AM, V19 (Certified Nursing Assistant/CNA) stated V19 just came up to the 4th floor 30 minutes ago to cover for a CNA that left the floor due to an emergency. V19 stated V19 has not seen R2 yet. V19 stated morning shift CNAs start at 7:00 AM and incontinence care should be provided to the residents at least every 2 hours and as needed. On 6/5/24 at 1:59 PM, V2 (Director of Nursing) stated, My expectation is the caregivers do their rounds frequently at least every 2 hours and as needed. They have to make sure that the resident is dry, and they provide incontinence care. We make sure that they provide care within the reasonable timeframe that's why they do frequent rounds because if it's not done that would lead to skin breakdown or discomfort. The facility's policy titled; Incontinence Care, dated 4/20/21, documents in part: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on observation, interview, and record review, the facility failed to ensure pressure reducing air mattresses were set according to the resident's weight for 5 (R75, R93, R134, R318, R418) of 8 (R27, R101, R571) residents reviewed for pressure ulcers in a sample of 34. Finding Include: 1. R75 has diagnoses not limited to Hyperlipidemia, Urinary Incontinence, Depression, Anxiety Disorder, Functional Quadriplegia, Urinary Tract Infection, Morbid (Severe) Obesity Due to Excess Calories, Cerebral Palsy, Chronic Pain Syndrome, Rheumatoid Arthritis and Ataxic Gait. R75's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response. R75's Care Plan documents: Resident is at risk for alteration in skin integrity related to: Limited Joint Mobility, Overweight/Obesity R75's Order Summary Report documents: Low Air Loss Mattress in use. Check for proper functioning and settings. every day shift Wound Care -Start Date- 04/26/24. R75's Preventive Interventions Worksheet, dated 05/27/27, documents: Most recent risk assessment 14 moderate risk. R75's weight dated 05/13/24 is 285.2 Lbs. (pounds), and 04/01/24 304.0 Lbs. On 06/04/24 at 11:06 AM, R75 was observed lying in bed on a low air loss mattress with the setting of 420. On 06/05/24 at 11:22 AM, R75 was observed lying in bed on a low air loss mattress with the setting of 420. Surveyor asked R75 her current weight and if she has any wound. R75 responded, The last time they weighed me it was 278. I used to have wounds. 2. R134 has diagnoses not limited to Gastrostomy, Dysphagia, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Dysarthria Following Cerebral Infarction, Obesity, Epilepsy, Aphasia Following Cerebral Infarction, Lack of Coordination, Abnormal Posture, Weakness, Need For Assistance with Personal Care, Pressure Ulcer of Sacral Region, Stage 4, Chronic Embolism and Thrombosis of Left Internal Jugular Vein, Metabolic Encephalopathy, Anemia, Functional Quadriplegia, Gastro-Esophageal Reflux Disease, and Hyperlipidemia. R134's Order Summary Report, dated 06/05/24, documents: Wound care (L (left) buttock) - cleanse with (nss) (normal saline) apply collagen to wound bed, cover with dry dressing every day shift for wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R134's Care Plan documents: Resident has PRESSURE INJURY to left buttock, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to: cognitive impairment, limited mobility, incontinence, dependence on staff, inability to communicate. Low air loss mattress in place with appropriate settings and functioning properly. Date Initiated: 02/27/24. Has potential for pressure ulcer development. History of ulcers, limited mobility, incontinence. R134's weights dated 05/06/24 is 165.4 Lbs., and 04/04/24 167.2 Lbs. On 06/04/24 at 12:06 PM, R134 was observed in bed asleep in a semi-Fowler position on a low air loss mattress set at 320, with an enteral feeding infusing at 60 ml/hr (milliliters/hour). On 06/04/24 at 12:08 PM, surveyor asked V20 (Licensed Practical Nurse) if R134 has any wounds. V20 responded, (R134) had wounds, but the number on the low air loss mattress is on 320. That is not (R134's) weight. On 06/05/24 at 11:25 AM R134 was observed in bed in a semi-Fowler position on a low air loss mattress set at 320. On 06/05/24 at 2:58 PM, V31 (Wound Care Nurse) stated, The purpose of the low air loss mattress is to prevent wounds from worsening or new wounds developing for residents that are high risk. The low air loss mattress setting is based on the weight of the resident. If the low air loss mattress is too soft or too firm there is a potential for complications, possible worsening of the existing wounds or cause new wounds. I believe (R75) can turn herself and is at is at moderate risk for skin breakdown. (R75) is on a low air loss mattress. If the low air loss mattress is set at 420, that is not the correct setting for (R75). The staff will change the setting when providing care and changing position but should return it back to the right setting after providing care. (R134) has wounds and her wounds are improving. (R134's) low air loss mattress setting of 320 is not the correct setting, and puts (R134) at greater risk for skin breakdown. If the low air loss mattress is firm, it can cause skin breakdown from too much pressure. Everyone that provide patient care is responsible for making sure the low air loss mattress is on the correct setting. We do rounds and check the settings. 40061 3. R93's Admission Record documents a medical diagnosis of pressure ulcer of sacral region, stage 4. R93's Order Summary Report documents multiple orders for wound care and low air loss mattress for pressure redistribution. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R93's care plan documents R93 has skin stripping to left groin, right grown, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to contractures, incontinence of bowel, incontinence of urine, infection current - or recent, limited joint mobility, and trauma (initiated 4/05/2024). It also documents R93 has pressure injury to sacrum, right trochanter, right posterior hip, left trochanter, right knee, right lower leg, left lateral lower abdomen, left knee is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to Braden Scale, history of pressure ulcers, immobility, incontinence of bowel, incontinence of urine, infection - current or recent, and limited joint mobility (initiated 4/05/2024). Intervention for both focuses documents: Low air loss mattress in place with appropriate settings and functioning properly (initiated 4/05/2024). On 6/04/2024 at 10:56 AM, R93 was lying in bed watching TV. R93's low air loss mattress was set to 'Static' setting. The weight knob was set between the 250-280 lb (pound) tick marks. At 10:59 AM, V6 (Nurse) stated, The wound care team saw (R93) this morning and probably forgot to readjust the settings. The setting should be at alternating pressure and not static. The weight setting should be set to (R93's) weight. V6 changed the setting to alternating, and adjusted the weight to 120 lbs. R93's Monthly Weight Report documents in part a recent weight of 111.6 lbs in May. 44103 4. R418's clinical records show R418 was admitted on [DATE], and weighed 147.2 pounds. R418 has diagnoses not limited to Dysphagia and Dementia. R418's clinical admission form, dated 6/1/24 at 10:59 PM, shows R418 is comatose. R418's Dietary Evaluation, dated 6/3/24 at 8:07 AM, shows R418 was assessed to be underweight and has pressure ulcers. R418's wound assessments, dated 6/2/24, show R418 has stage 4 right buttock and unstageable left heel pressure ulcers. On two separate occasions, dated 6/4/24 at 10:46 AM and 6/5/24 at 12:31 PM, Surveyor observed R418 sleeping in bed. R418's low air loss mattress' weight control knob was set to 210 pounds. On 6/5/24 at 1:59 PM, V2 (Director of Nursing) and stated low air loss mattress is used to prevent wound from getting worse and helps with wound healing. V2 stated it's used for residents who are mostly in bed and who are the tendency to develop wounds. V2 stated wound care nurses set up the low air loss mattress based on the resident's current weight. On 6/5/24 at 3:13 PM, V36 (Wound Care Nurse) stated R418 has stage 4 sacral ulcer and a left heel ulcer. V36 stated a setting of 210 pounds for R418's low air loss mattress is too high if R418's weight is 147.2 pounds. 46342 5. On 06/04/24 at 10:41 AM, R318 was lying in bed on low air loss mattress. Drive low air loss mattress was set at 350 pounds, which was the highest weight listed on the dial, and the word FIRM was written near the 350-pound weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 10:52 PM, V10 (Licensed Practical Nurse) observed R318's low air loss mattress setting and verbalized, It is set at 350 pounds which is the firmest setting. V10 stated R318 does not look as if he (R318) weighs 350 pounds. V10 stated the air loss mattress setting should be set based on the resident's weight, and R318 has multiple wounds, which is why R318 needs the low air loss mattress. On 06/05/24 at 12:24 PM, R318 was lying on low air loss mattress. Drive low air loss mattress set at 250 pounds. On 06/05/24 at 3:07 PM, V36 (Wound Care Nurse) stated R318 has multiple pressure wounds. V36 stated R318's wounds are not facility acquired. V36 stated R318's wounds have been stable and R318 is using an air loss mattress as an intervention for wound healing. V36 stated the air loss mattress setting is based on R318's weight. V36 stated 350 pounds is not the correct setting based on R318's weight. V36 stated if R318 weighs 208 or 209 pounds, thwn the air loss mattress should be set closer to 200 pounds instead of 250 pounds. V36 stated if the weight is set too high, then the mattress could become too firm and cause new skin breakdown from the increased pressure, and/or there could be a deterioration of the wounds R318 currently has. R318's diagnosis included but not limited to Pressure Ulcer of Sacral Region Stage 4, Pneumonia, Type 2 Diabetes Mellitus with Hyperglycemia, Dilated Cardiomyopathy, Enterocolitis due to Clostridium Difficile Not Specified As Recurrent, Chronic Kidney Disease Stage 3B, Elevated [NAME] Blood Cell Count, Hypothyroidism, Peripheral Vascular Disease, Abnormalities of Gait Mobility, Unsteadiness on Feet, Unspecified Atrial Fibrillation, Hypertension, Embolism and Thrombosis of Other Specified Veins, Hyperlipidemia, Anemia, Slowness And Poor Responsiveness. R318's Order Summary Report, dated 06/05/24, documents, low air loss mattress for pressure redistribution start date 05/12/24. R318's Wound Report, dated 06/05/24, documents left heel unstageable pressure wound, left ischial tuberosity stage 4, left scapula stage 3, right ischium lateral stage 3, right ischium medial stage 3, right lateral distal foot deep tissue pressure injury, right lateral lower leg to malleolus unstageable, right lateral mid foot deep tissue pressure injury, right posterior thigh proximal stage 3, right heel unstageable, right toe(s) arterial insufficiency full thickness, sacrum stage 4. R318's care plan, dated 05/12/24, documents R318 has pressure injury to right ischium medial, right ischium lateral, left is ischium, left heel, left scapula, sacrum, right posterior thigh, right lateral distal foot, right lateral lower leg to malleolus, right lateral midfoot, right heel and intervention include but not limited to low air loss mattress in place with appropriate settings and functioning properly. R318's Weight Summary Report, printed 06/06/24, documents weight dated 05/16/24 208.6 pounds; weight dated 06/06/24 208.6 pounds. R318's MDS (Minimum Data Set) from 05/15/24 BIMS (Brief Interview for Mental Status) score is 08 out of 15, indicating cognition is moderately impaired and substantial/maximal assistance is needed for oral hygiene, toileting, shower/bathing, personal hygiene, roll left to right and dependent for sit to lying and lying to sitting on side of bed. (continued on next page)

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	145484	A. Building B. Wing	06/07/2024

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided User Manual to Drive Low Air Loss Mattress System Item #14530 which documents, 1.) The intended use are intended to help reduce the incident of pressure ulcers while optimizing patient comfort. 2.) Pressure adjust knob adjustable by patient's weight. Facility provided a copy of low air pressure mattress company's user manual. It documents: [product name] is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Control and features include: Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide and Turn the switch to 'Alternating' to turn on the alternating pressure function. Turn the switch to 'Static' to turn on the static mode. NOTE: In static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. Policy: Titled Pressure Ulcer Prevention revised 01/15/18 document: Purpose: To prevent and treat pressure sore/pressure injury. Guidelines: 9. Pressure reducing (foam) mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds. Facility's Pressure Ulcer Prevention policy, last revised 1/15/18, does not document procedural instructions for use of low air loss mattress and their settings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 39779 Based on observation, interview, and record review, the facility failed to ensure a resident's bilateral splints were placed per the plan of care and update the care plan to reflect the resident preferences for 1 (R101) of 2 residents reviewed for positioning and limited range of motion in a sample of 34. Findings Include: R101 has diagnosis not limited to Quadriplegia, C5-C7 Incomplete, Quadriplegia, C1-C4 Incomplete, Moderate Protein-Calorie Malnutrition, Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Autonomic Dysreflexia, Epilepsy, Hypertensive Heart Disease, Depression, Anemia, Neuromuscular Dysfunction of Bladder, Insomnia, Gastro-Esophageal Reflux Disease, Post-Traumatic Stress Disorder, Personal History of Sudden Cardiac Arrest, and Peripheral Vascular Disease. R101 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response. R101's Order Summary Report documents: Apply wrist Splint to bilateral upper extremities. on during morning, off during ADL (Activities of Daily Living) care and off before PM care, every day shift *Apply in the morning. Apply wrist Splint to bilateral upper extremities. on during morning, off during ADL (Activities of Daily Living) care and off before PM care, every evening shift *Remove before PM care. R101's Care Plan documents: Focus: R101 would benefit from a PROM (passive range of motion) program due to R101 has actual contractures. Date Initiated: 01/22/24. Focus: Would benefit from use of wrist Splint/Brace Date Initiated: 02/23/24. R101's Progress note, dated 07/27/23 10:59, documents: - Restorative Nursing Screener / GG Evaluation Details: Self-Care: Dependent. Functional Cognition: Independent. Motorized wheelchair and /or scooter. Resident is currently prescribed to wear a splint or brace. Resident is able to effectively communicate using their current method(s). R101's Restorative Contracture Observation, dated 04/25/24, documents: 1. Current Range of Motion Status. C. The resident has limitations in range of motion as noted. 2. Range of Motion (ROM) Evaluation Scale. C. Left Wrist 2. Moderate contracture of specific joint. Displays 50-70% of normal range. D. Left hand 2. Moderate contracture of specific joint. Displays 50-70% of normal range. J. Right wrist 2. Moderate contracture of specific joint. Displays 50-70% of normal range. K. Right hand 2. Moderate contracture of specific joint. Displays 50-70% of normal range. On 06/04/24 at 11:40 AM, R101 was observed lying in bed on a low air loss mattress. Contractures were observed to both hands with no splints in use. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/24 at 09:57 AM, R101 was observed lying in bed on a low air loss mattress. Contractures were observed to both hands with no splints in use. R101 stated, I have not had the splints on for a while. I am asking to not have the splints on. I have some movement to my wrist and can press my hands against my chest to spread my fingers. On 06/05/24 at 2:33 PM, V30 (Restorative Nurse) stated, (R101) receives passive range of motion. R101 has bilateral wrist splints on in the morning, off during ADL care and off before PM care. The time frame let's say is from 7am - 3pm. I have seen (R101) with the splints when up in the chair. If (R101) is refusing to wear the splints we would ask why, educate and redirect. I am not sure if the restorative aide is charting the splints. The bilateral hand splints are a recommendation. It depends on the resident if they want the splints on in the morning or evening. If they don't want the splints on, we can use palm protector if appropriate. (R101) said the splints helps when he controls the power chair. The purpose of the wrist splints is to prevent the wrist from contracting. Occupational therapy needs to reevaluate (R101). I will talk to (R101), update the care plan, order, and task. (R101's) preference should be care planned. On 06/06/24 at 11:19 AM, V31 (Occupational Therapist) stated, (R101) can position hands in a neutral position. (R101) is alert and oriented. Based on the restorative order, (R101) should have the bilateral hand splints on. Restorative changed the order yesterday to (R101's) preference. R101's Order Summary, dated 06/05/24, documents: Apply wrist Splint to bilateral upper extremities as needed/per resident request as needed for to prevent contracture per resident request. Progress note dated 06/05/24 16:56 document in part: Writer, OT (Occupational Therapy) and PT (Physical Therapy) went over patient's wrist splint scheduling times and he prefers as needed/per resident request. Restorative Nursing Program Observation dated 06/06/24 document in part: IV. Splint or Brace Assistance 1a. bilateral wrist splints. 7. Additional Notes: scheduling times as per resident request/as needed. R101's care plan was not updated to reflect his preference of not wearing the wrist splints. Policy: Titled Resident Rights reviewed 01/04/19 documents, Purpose to promote the exercise of rights for each resident. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to facility's rules, as long as those rules do not violate a regulatory requirement. Facility practices designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Titled Restorative Nursing Program reviewed 01/04/19 documents: Purpose: To promote each resident's ability to maintain or regain the highest degree of independence as safely as possible. Includes, but not limited to programs in walking/mobility, dressing and grooming, eating and swallowing, transferring, bed mobility, communication, splint or brace assistance, amputation care and continence programs. Each resident involved in a restorative program will have an individualized program with individualized goals and measurable objectives documented on the plan of care. Develop and individualized program based on the resident's restorative needs, and include the restorative program on the care plan. The restorative nurse or designee will review the restorative program at least quarterly and as needed for appropriateness of that individual plan and will document a note on the appropriate form. This will include reviewing the program goals, interventions, patient tolerance, and any recommended changes to the plan. The resident care plan will also be reviewed and updated at least quarterly and as needed by the restorative nurse or designee. Titled Comprehensive Care Plan revised 11/17/17 documents: 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 psychosocial well-being. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44103 Based on observation, interview, and record review, the facility failed to secure their Central Supply Room to ensure it is inaccessible by residents and visitors. This failure has the potential to affect the 55 residents that are mobile about the facility. The facility also failed to ensure equipment that could cause a fire hazard was out of a resident's room for 1 (R78) out of a final sample of 34 residents reviewed for safety hazards. Findings Include: 1. On 6/04/24 at 10:36 AM, R78 was resting in bed alert and verbally responsive. Surveyor noted a black space heater by R78's bed that was turned on. R78 stated the facility provided the space heater to use. On 6/05/24 at 9:55 AM, Surveyor and V21 (Director of Environmental Services) entered R78's room and noted R78's space heater by R78's bed that was turned on. R78 stated the Maintenance Department provided the space heater because R78 is always cold. V21 stated space heaters are not allowed anywhere inside the building because they are fire hazards. V21 stated the residents are not supposed to have space heaters in their rooms. The facility's policy titled; SAFETY/HAZARD SURVEILLANCE POLICY, dated 2/14, documents: To promote an environment for residents, staff and visitors that is free from safety hazards and to assure all facility are in compliance with local and state regulations. 40061 2. On 6/04/2024 at 1:56 PM, V1 (Administrator) directed surveyor to the Central Supply Room. Door was propped open with a door stopper. There were no employees in the room. Over the counter (OTC) medications including stool softeners and antacids were on an open shelf. V1 called V9 (Central Supply Coordinator) via cell phone. V9 was on the third floor and V9 stated will head down to meet surveyor. V1 left surveyor in Central Supply Room unattended. At 1:59 PM, V9 directed surveyor to alternate supply room near the elevators leaving the Central Supply Room unattended and unlocked. When surveyor and V9 returned to Central Supply Room, the door remained propped open. V9 stated residents do sometimes come down to the area to speak with kitchen and laundry staff. V9 stated Central Supply Room holds most of the resident care equipment including pumps, intravenous poles, wipes, pads, nail clippers and over the counter medications. V9 showed surveyor an unlocked metal cabinet that contained additional over the counter medications including Aspirin, Acetaminophen, Ibuprofen, Sodium Bicarbonate, and multiple vitamins. On 06/06/2024 at 11:32 AM, V3 (Assistant Director of Nursing) stated the Central Supply Room should be locked. V3 stated everything that has to do with medications has to be locked because there are residents with behavioral concerns and V3 would not want them going through unprescribed medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Medication Storage policy, last revised 7/2/19, documents: Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Facility's Job Description for Central Supply Coordinator documents: To ensure that nursing and medical supplies are available, accessible, organized, and secure, that par levels of supplies are maintained, and that facility medical equipment is clean, inventoried, and available and that it is returned timely as indicated. Essential duties and responsibilities include: observe all facility safety policies and procedures and Be responsible for safety, identify safety hazards and initiate corrective action.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46342 Based on observation, interview, and record review, the facility failed to prevent urinary drainage bag from touching the floor for one (R318) out of 1 resident reviewed for urinary catheter in a sample of 34. Findings Include: R318's diagnoses include Pressure Ulcer of Sacral Region Stage 4, Pneumonia, Type 2 Diabetes Mellitus with Hyperglycemia, Dilated Cardiomyopathy, Enterocolitis due to Clostridium Difficile Not Specified As Recurrent, Chronic Kidney Disease Stage 3B, Elevated [NAME] Blood Cell Count, Hypothyroidism, Peripheral Vascular Disease, Abnormalities of Gait Mobility, Unsteadiness on Feet, Unspecified Atrial Fibrillation, Hypertension, Embolism and Thrombosis of Other Specified Veins, Hyperlipidemia, Anemia, Slowness, And Poor Responsiveness. R318's care plan, dated 05/16/24, documents R318 has an indwelling catheter neurogenic bladder and interventions include to monitoring for signs and/or symptoms of urinary tract infection. R318's MDS (Minimum Data Set) from 05/15/24 BIMS (Brief Interview for Mental Status) score is 08 out of 15 indicating cognition is moderately impaired. On 06/04/24 at 10:41 AM, R318 was lying in bed, with R318's urinary drainage bag lying on the floor next to the bed. The urinary drainage bag was not in a privacy cover or other type protection to prevent from directly touching the floor. On 06/04/24 at 10:48 AM, V10 (Licensed Practical Nurse) observed R318's urinary drainage bag lying on the floor. V10 stated, The bag is not supposed to be touching the floor due to infection control concerns so it stays clean. On 06/06/24 at 1:20 PM, V16 (Infection Prevention Director/Licensed Practical Nurse) stated urinary drainage bags should be hooked onto the bed frame and the urinary drainage bags should not be on the floor because it puts the resident at a higher risk for potential infection. V16 stated bacteria could go up the tube and then go directly into the resident's bladder. V16 stated having the urinary drainage bag on the floor could put a resident at increased risk for acquiring a urinary tract infection. V16 stated R318 has an indwelling catheter. Facility provided policy titled, Catheter Care, dated 02/14/19, documents to establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter and guidelines include but not limited to urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40061 Based on observation, interview, and record review, the facility failed to follow physician orders and provide house nutritional supplements for two (R108 and R148) residents out of a total sample of 34 residents. Findings include: 1. R148's Admission Record documents medical diagnosis of adult failure to thrive. Dietary progress note, dated 3/21/2024 9:10 AM, documents, secondary to significant weight loss, writer recommends increasing House Supplement 1 carton to [three times a day] to promote additional [kilocalorie] and protein for weight maintenance or gain. R148's Order Summary Report documents an active order for House Supplement three times a day 1 carton for supplementation (ordered 3/21/2024). R148's Care Plan documents an intervention initiated on 3/22/2024 for house supplement one carton three times a day. On 6/04/2024 at 11:10 AM, R148 was alert and oriented to person and place. R148 stated R148 was hungry and R148 was asking about food. At 12:23 PM, R148 was eating lunch. Lunch tray had chili dog, green beans, sweet potato, banana pudding, apple juice, and 2% milk. Surveyor asked if facility provides nutritional shakes. R148 shook head no. At 12:27 PM, while at the nurses' station, surveyor asked V6 (Nurse) if R148 receives a house supplement. V6 initially stated yes, and started naming vitamin pills. Surveyor clarified house supplement and not oral pills. V6 then pointed to critical care supplement. Surveyor asked if that is what R148's physician order is referring to. V3 (Assistant Director of Nursing stated they will look at the order together. V3 and V6 reviewed R148's physician orders on the computer. V6 stated it was a special order that came from downstairs. V3 and V6 stated Dietary brought up the house supplements. V3 stated, It isn't kept on the floor and Dietary will bring it up with the meals or bring it up in between meals. V3 stated according to the orders, R148 should receive it three times a day. At 12:37 PM, V4 (Cook) stated nurses supply the house supplement to the residents, not the kitchen. At 12:43 PM, V5 (Diet Tech) stated nurses give the house supplement to the residents, not kitchen. V5 reviewed R148's orders in the electronic medical record. V5 stated Yup, [R148] is supposed to get it three times a week. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:59 PM, V9 (Central Supply Coordinator) stated the facility has multiple types of house supplements in stock. Surveyor observed at least three different nutritional supplement shakes in the supply room. When asked if R148 receives house supplement, V9 stated R148's name was not familiar and doesn't recall any nurse requesting for house supplement for R148. V9 stated usually the nurses will inform V9 if there's a need for house supplement, and V9 will send a box up. If needed, the nurses or certified nurse aides can come downstairs and retrieve a box of supplements. At 2:29 PM, surveyor reviewed R148's May 2024 MAR with V6 at the nurses' station. V6 stated initials for 5/01, 5/02 and 5/04 belonged to V6. Surveyor asked what V6 administered as a house supplement this morning. V6 stated Dietary provides it. Informed V6 of interview with V4 and V5. V6 stated, I don't have it. I didn't give it. V3 asked V6 Are you saying you are not giving it? V6 stated, I don't have it. We don't keep it on the floor. I don't give it. On 6/06/2024 at 9:18 AM, V33 (Dietician) stated the recommended house supplement for R148 is (supplement name). The purpose of it is to give R148 the additional nutrients. The facility will have it in stock on the floors and the nurses are to give it to the residents. Facility's undated Fortified Foods policy from their Diet Manual documents: Individualize the patient's meal plan to meet their nutrition needs by incorporating snacks, ONS (oral nutritional snacks), and fortified foods. Tips for managing a successful fortified foods program include: Offer the fortified food either with or between meals. ONS are another way to add concentrated nutrition or to increase a snack's protein/calorie content. 39779 2. R108 has diagnosis not limited to Displaced Comminuted Fracture of Shaft of Right Femur, Traumatic Subdural Hemorrhage with Loss of Consciousness of 30 Minutes or Less, Type 2 Diabetes Mellitus with Hyperglycemia, Type 2 Diabetes Mellitus with Diabetic Nephropathy, Obesity, Anemia in Chronic Kidney Disease, Atherosclerotic Heart Disease of Native Coronary Artery, Hypertensive Heart and Chronic Kidney Disease with Stage 5 Chronic Kidney Disease, Dependence on Renal Dialysis, Epilepsy, Dysphagia, Abnormalities of Gait and Mobility, Lack of Coordination, Abnormal Posture, Cognitive Communication Deficit, and Elevated [NAME] Blood Cell Count. R108's Order Summary Report documents: Nepro one time a day 1 carton for supplementation. Dialysis (Renal) Consistent Carbohydrate diet Regular texture. R108's Care Plan documents: Resident is on therapeutic diet. Nepro 1 carton qd (every day). On 06/04/24 at 09:14 AM, surveyor and V20 [Licensed Practical Nurse] during medication administration, observed R108 medication preparation. V20 stated, I will sign out (R108's) nutritional supplement, because the kitchen sent up the drink on (R108's) breakfast tray this morning. On 06/04/24 at 09:15 AM, R108 stated, No I did not receive any nutritional drink on my breakfast tray. Surveyor and V20 looked at R108 ' s breakfast tray, bedside table and garbage can; there was no nutritional supplement drink observed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/24 at 09:20 AM, V20 stated, I will call the kitchen staff and asked them to send up (R108's) nutritional supplement drink. On 06/04/24 at 11:23 AM, R108 was observed sitting on the bed consuming lunch that consisted of a hamburger on a bun, corn, string beans, pudding, and coffee. There were 4 bottles of (nutritional supplement) on the overbed table next to the meal tray that R108 stated his brother brought him. R108 denied receiving the ordered Renal specific house supplement. On 06/05/24 at 11:23 AM, R108 stated, I did not receive the supplement today. On 06/05/24 at 11:42 AM, surveyor asked V20 (Licensed Practical Nurse) was the (renal nutritional supplement) available. V20 stated, We use to have it. I did not give (R108) the (renal nutritional supplement) this morning. At times, (R108) will request it and anytime (R108) wants it, we will give it to him. Dialysis residents receive the (renal nutritional supplement). I have not given it to (R108) today. (R108) is alert and oriented x3 and should be able to tell you if he received the (renal nutritional supplement). On 06/05/24 at 11:49 AM, V20 (licensed Practical Nurse) provided the surveyor with a bottle of the (renal nutritional supplement). The surveyor entered R108's room with V20 (Licensed Practical Nurse). The surveyor showed the bottle of (renal nutritional supplement) to R108 and asked if he had received any of the (renal nutritional supplements). R108 responded No. V20 stated, I gave you the (renal nutritional supplement) yesterday. R108 stated, I never get that, why would I lie. I'm telling you I drink the ones that my brother brings me. On 06/06/24 at 9:24 AM, V33 (Registered Dietitian) stated, We have the house supplements in stock on the floor and the nurse gives it to the resident when ordered. The dialysis residents have (renal nutritional supplement) on the floor and there is a room that has the supplements. If the supplements are ordered for 9am they should be given at that time. (R108) gets (renal nutritional supplement) because he is on dialysis. The (renal nutritional supplement) was added back in April one time a day for additional calories, protein and for weight maintenance to give extra nutrients that (R108) loses through dialysis. (R108) should not be drinking (nutritional supplement) because it could have a higher amount of electrolytes. (Nutritional supplement) should not be used for dialysis residents. 45110

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to ensure a physician's order and Dietary recommendation for feeding rate were followed for 1 (R418) out of 3 residents reviewed for enteral feedings in a final sample of 34. Findings Include: R418's clinical records show R418 was admitted on [DATE] and weighed 147.2 pounds. R418 has diagnoses not limited to Dysphagia and Dementia. R418's clinical admission form, dated 6/1/24 at 10:59 PM, shows R418 is comatose. R418's physician order shows R418 to receive enteral feeding of Nepro 1.8 at 70 ml/hr for 18 hours to infused 1260 ml total. This was ordered on 6/03/24. R418's Dietary Evaluation, dated 6/3/24 at 8:07 AM, shows R418 was assessed to be underweight and has pressure ulcers. V33 recommended for the enteral feeding to be increased at 70 ml/hr for 18 hours that will provide 33 kcal/kilogram. On 6/4/24 at 10:46 AM, R418 was sleeping in bed. R418 was receiving Nepro 1.8 enteral feeding at a rate of 45 ml (milliliters)/hour (hr). V13 (Registered Nurse) was in R418's room and confirmed R418's enteral feeding was at the correct setting. On 6/5/24 at 12:31 PM, R418 was in bed sleeping. R418's enteral feeding was turned off. Enteral feeding bottle was hanging at R418's bedside, still at approximately 75% full. On 6/5/24 at 1:59 PM, V2 (Director of Nursing) stated V2's expectation for the residents' enteral feedings is that the nurse follows the doctor's order. V2 stated, First of all, the nurses have to contact the Dietitian, and the Dietitian usually gives the recommendation and the recommendation is being endorsed by the physician, so they will have the physician's order. The g-tube [gastrostomy tube] feeding is already programmed in the machine. So when they program the machine, it has the rate and it will automatically stop when it's done. They have to program the g-tube feeding at a rate based on the doctor's order. Once it's programmed, it can only be put on hold when they are giving medication and incontinence care. On 6/6/24 at 9:10 AM, V33 (Registered Dietitian) stated R418 was admitted on [DATE] and weighed 147.2 pounds. V33 stated R418 is underweight and should be getting the enteral feeding at 70 ml/hr for 18 hours; that would provide 2230 kilocalories (kcal) a day. V33 stated R418 was previously getting enteral feedings at 45 ml/hr for 18 hours, but it was not sufficient for R418's weight. V33 recommended to increase the feedings at 70 ml/hr for 18 hours. V33 stated it's important to follow the recommended and ordered enteral feeding rate to make sure R418 at least maintains or is able to gain a little weight. V33 stated, We don't want [R418] to lose weight if [R418's] not getting [R418's] feeding what is supposed to. The facility's policy titled; Gastrostomy Tube- Feeding and Care, dated 8/3/20, documents: To provide nutrients, fluids and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observations, interviews, and record reviews, the facility failed: to date and label oxygen tubing for 1 (R94) resident; label Nasal Cannula for 1 (R133) resident; store nebulizer machine and mask inside a plastic bag when not in use for 1 (R35) resident; date and change oxygen equipment weekly per physician order for 1 (R55) resident; administer oxygen as ordered for one resident (R31); and correctly store unused oxygen tubing in two resident's rooms (R31, and R138). These failures affect 6 (R31, R35, R55, R94, R133, and R138) residents in a sample of 34. Findings Include: 1. During the annual recertification survey, dated 06/4/24 to 06/07/24, surveyor observed R94 on ventilator with undated oxygen tubing. On 06/5/24 at 10:46 AM, V27 (Respiratory Therapy Director) stated, The Nasal Cannula tubing should be changed and dated every Sunday/weekly. The oxygen tubing for the vent (ventilator) residents should be changed and dated to minimize the risk of infection transmission. On 06/05/24 at 10:58 AM, V17 (Registered Nurse/RN) stated V17 has been working in the facility for 10 months. V17 stated the Oxygen tubing should be changed weekly and as needed, and dated. V17 stated when the oxygen tubing is not dated, the staff will not know when the tubing was changed and that can increase the risk of infection for the resident. On 06/05/24 at 11:00 AM, V26 (RN/Supervisor) stated the oxygen tubing should be dated and changed every week and as needed. If an oxygen tubing is not dated, it means the tubing was not changed and that will put the resident at risk for infection. On 06/05/24 at 11:49 AM, V16 (Infection Prevention Nurse) stated Nebulizing mask/tubing, Nasal Cannula and oxygen tubing should be changed weekly and as needed and dated to prevent respiratory infection. When the Nebulizer machine is not in use, the mask should be stored in a clean plastic bag. Unchanged and undated oxygen tubing exposes resident to infection. Facility Policy titled, Care and Cleaning of Respiratory Equipment dated 12/1/2021 documents in part: To maintain equipment in proper working order and to reduce the risk of nosocomial infection. All disposable respiratory equipment is labeled with date when placed in use. Facility Policy titled, Oxygen & Respiratory Equipment-Changing/Cleaning dated 1/7/19 documents in part: A clean plastic bag with a Ziploc will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed. 40061 2. R133's Admission Record documents in part medical diagnoses including but not limited to chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R133's Order Summary Report documents in part active orders to change oxygen tubing and humidifier every night shift every seven days and as needed (ordered 4/25/2024). On 6/04/2024 at 9:59 AM, R133 was lying in bed and receiving oxygen via nasal cannula. The nasal cannula was not dated or labeled. Facility's Oxygen & Respirator Equipment-Changing/Cleaning policy, last revised 1/7/19, documents the nasal cannula will be dated with the date the tubing was changed. 44103 3. On 6/04/24 at 12:11 PM, R35 was lying in bed alert and verbally responsive. R35's nebulizer machine was turned on, but R35 was not using it. Nebulizer mask was sitting on top of the nebulizer machine, not inside a clear bag, and not labeled with a date when it was last changed. R35's clinical records show as admitted [DATE] with listed diagnoses not limited to Chronic Obstructive Pulmonary Disease (COPD). R35's Minimum Data Set (MDS), dated [DATE], shows R35 is moderately impaired with cognition and requires substantial maximal assistance for activities of daily living (ADLs). R35's physician order sheet has an order that reads: Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0. 5ML (Albuterol Sulfate)1 vial inhale orally via nebulizer every 4 hours as needed for shortness of breath ordered on 9/7/2023. Facility's policy titled; NEBULIZER THERAPY, dated 12/1/2021, documents: nebulizer equipment to be stored in a plastic bag, and to change mouthpiece tubing and nebulizer weekly. 46342 4. On 6/04/24 at 10:25 AM, R55 was lying in bed, with nasal cannula in place and oxygen infusing. R55 stated R55 uses oxygen continuously. R55 stated the staff changes R55's oxygen tubing every 1-2 months. Observed humidifier bottle dated 04/08/24, and nasal cannula tubing dated 04/08/24. On 06/04/24 at 10:29 PM, V2 (Director of Nursing) stated, We don't change the oxygen tubing every day. I don't know if we change the oxygen tubing every week or every other week. The night charge nurse is the one who changes the oxygen tubing. They should be dating the tubing and the humidifier bottle due to infection control purposes, and if the tubing is old and not changed, it can accumulate 'some pathogens.' V2 viewed R55's humidifier bottle and oxygen tubing and said, They are both labeled on the same day, 04/08/24. R55 has diagnoses which includes but not limited to Acute and Chronic Respiratory Failure with Hypoxia, Acute and Chronic Respiratory Failure with Hypercapnia, Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Combined Systolic (Congestive) And Diastolic (Congestive) Heart Failure, Acute Kidney Failure, Metabolic Encephalopathy, Schizoaffective Disorder, Borderline Personality Disorder, Lack of Coordination, Anxiety Disorder, and Insomnia. R55's Order Summary Report, dated 06/05/24, documents change oxygen tubing and humidifier every night shift every 7 days with start date 06/29/23. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55's MDS (Minimum Data Set) from 04/11/24 BIMS (Brief Interview for Mental Status) score is 15 out of 15, indicating intact cognition and while a resident using oxygen therapy. R55's nursing care plan, dated 07/20/23, documents R55 has oxygen therapy and interventions include but not limited to change oxygen tubing and humidifier every night shift on Sunday. Facility provided policy titled, Oxygen & Respiratory Equipment Changing/Cleaning, dated 01/07/19, documents purpose to ensure the safety of residents by providing maintenance of all disposable respiratory supplies and to minimize the risk of infection transmission. Procedure documents in part, nasal cannulas are to be changed once a week and PRN and oxygen humidifiers should be changed weekly or as needed and will be dated when changed. 50057 5. On 06/04/24 at 9:35 AM, R31's oxygen machine was observed turned off at R31's beside. Oxygen tubing was observed laying on the bedside table and not in a bag. On 06/04/24 at 12:22 PM, V42 (Certified Nursing Assistant/CNA) was at R31's bedside. Oxygen was not on resident, and oxygen machine was turned off. V42 stated, They took her oxygen off of her a few days ago. (R31) can have it if she needs it. V42 pulled tubing from under R31's pillow, which was behind R31's head. Oxygen tubing was not in a bag. On 06/04/24 at 12:24 PM, V10 (Licensed Practical Nurse/LPN) stated R31 uses her oxygen. V10 stated, I checked her oxygen saturation every morning. Her oxygen saturation was 97% this morning. V10 stated, I found her oxygen off this morning and put it back on her. I don't know why it is turned off again. Surveyor and V10 observed oxygen machine to be off and oxygen tubing not in a bag and behind R31's pillow, which was behind R31's head. V10 stated, The tubing should be in a plastic bag. It is not. V10 checked R31's oxygen saturation it was 93%. V10 stated, Her oxygen should be on her. V10 started oxygen therapy at two liters per minute. V10 stated oxygen tubing gets changed once every 4 weeks. On 06/04/24 at 02:27 PM, R31's oxygen therapy order was observed with V10 (LPN). V10 stated R31's order was for oxygen at continuous three liters per minute. V10 stated she set it to two liters per minute. V10 stated, I will change it from two liters to three liters now. On 06/04/24 at 12:52 PM, the oxygen therapy order for R31 was observed in the electronic health record to be: Oxygen three liters continuous via nasal cannula. The order date was 1/5/2024. 6. On 06/04/24 at 10:45 AM, a portable oxygen tank was observed at the foot of R138's bed. Oxygen tubing was observed laying on the floor and not in a bag. On 06/04/24 at 11:07 AM, there was observed to be no order for oxygen therapy for R138 in the electronic medical record. On 06/04/24 at 12:32 PM, V10 (LPN) and surveyor observed the portable oxygen tank with oxygen tubing connected to the oxygen tank and the nasal cannula laying on the floor in R138's room. V10 stated, That oxygen is not (R138's). I don't know who it belongs to. It may have been for her roommate. Oxygen tank and tubing removed from R138's room by V10. (continued on next page)

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	145484	A. Building B. Wing	06/07/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxygen Therapy Policy dated 12/1/2021 stated: Purpose: To deliver oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. Policy: It is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care. Procedure: I. Physician Order a.) verify physician's order. II. Set up and Administration of oxygen b.) attach the nasal cannula/mask to the oxygen source and turn the flow meter to the ordered flow rate of FiO2.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on observation, interview, and record review, the facility failed to follow their Storage of Medications policy and store medications in locked compartments for 2 [R69, R107] residents on 2 of 5 medication carts and 1 of 4 medication storage rooms; failed to label individual resident's insulin [NAME] with an open/expiration date for 2 [R157, R571] residents; failed to follow their policy to discard expired insulin for 1 [R34] resident; and failed to follow pharmaceutical storage instructions to refrigerate unopened insulin for 2[R112, R157]in 1 of 5 medication carts reviewed for medication storage, in a sample of 34. Findings include: 1. On [DATE] at 9:03AM, surveyor observed V20 [Licensed Practical Nurse] and surveyor inventoried the first-floor medication cart. The following were observed: *R34- Insulin Aspart solution 100 units/ml, expiration date of [DATE] written on the vail. [Physician order dated [DATE]. Give per slide scale with meals] *R112- A closed vail of Humalog insulin solution 100 units/ml. On the box was a label Refrigerate until Open. The insulin can only be a room temperature for 28 days, then discard. [Physician order dated [DATE]. Give per slide scale with meals] *R157-(1) A closed Lantus Solution 100 unit/ml [Insulin /Glargine]. On the box was a label read Refrigerate until Open. The insulin can only be a room temperature for 28 days, then discard. (2) Open half-filled vial of Lantus Solution 100 unit/ml [Insulin /Glargine]. No open/expiration date on vail or box. On the box label read Refrigerate until Open. The insulin can only be a room temperature for 28 days, then discard. [Physician order dated [DATE]] Give 109 units at bedtime] *R571- Open half-filled vial of Humalog insulin solution 100 units/ml. No open/expiration date on vail or box. On the box label read Refrigerate until Open. The insulin can only be a room temperature for 28 days, then discard. [Physician order dated [DATE]. Give 5 units before meals.] On [DATE] at 9:45 AM, V20 stated, The insulin should be dated upon opening and unopened insulin should be kept in the refrigerator until it is opened. I did not place the unopened insulin on the cart. I am not sure how long the unopened insulin has been in the cart. If I removed the insulin from the refrigerator, I would have dated the insulin right away. I have not given any insulin today. 2. On [DATE] at 12:17 PM, surveyor and V6 [Licensed Practical Nurse] observed the inside of R69's personal refrigerator, one jar of glycerin rectal suppositories and three boxes of Bisacodyl rectal suppositories 10mg. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] V6 stated, The jar glycerin rectal suppositories and three boxes of Bisacodyl rectal suppositories 10mg are both the facility house stock medications. Both the medications should be kept in the locked medication room refrigerator. We kept the medication in his refrigerator for convenience, of quick administration of the suppository. The reason medications need to be locked up, is for safety of the residents. On [DATE] at 12:33 PM, V2 [Director of Nursing] stated, Insulin should be kept in the refrigerator until opened. Once the insulin is removed from the refrigerator the nurse should place an open and expiration date on the insulin. Expired insulin should be discarded on or before the expiration date. If undated, or expired insulin is given to a resident the insulin will not be effective and could potentially cause harm to the resident. No medications should be kept in any resident personal refrigerator. Refrigerated medications should be kept inside the medication room refrigerator. If medication is left and stored in a resident's room personal refrigerator, any resident could potentially ingest or misuse the medication and cause illness to the resident. Policy documents: Medication Storage date [DATE] -To ensure proper storage, labeling, and expiration dates of medications, and biologicals -Facility should ensure that all medications and biologicals, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. -Facility to ensure that medications and biologicals that have an expired date on the label and are not retained longer than recommended by supplier guidelines. Pharmacy -Administration of medications dated [DATE]. - Prior to administer medication check expiration date on package before administering any medication. When opening a multi-dose container, place on the container. Pharmacy - Storage of Medications dated [DATE]. -Medications and biologicals are stored at their appropriate temperatures and humidity -Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degress-46 degrees Fahrenheit Pharmacy Expiration dates for certain biologicals -Insulin Vials expire in 28 days unrefrigerated 49486 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On [DATE] at 10:15 AM, surveyor observed two medication bottles at R107's bedside table. R107 stated R107 have Jardiance 10 mg tablet plus metformin 1000mg tablet in the Jardiance bottle, and Ibuprofen 200mg in the other bottle. Surveyor observed white oval shaped 4 tablets of metformin and round yellow 8 tablets of Jardiance inside the Jardiance bottle, and 15 brown round tablets inside Ibuprofen bottle. R107 stated R107 takes the Ibuprofen for wound pain daily as needed, and R107 took one tablet of 200mg Ibuprofen two days ago. R107 takes 2 tablets of metformin and one tablet of Jardiance daily for R107's Diabetes. R107 stated R107's doctor gave the medications to R107 during last hospitalization and R107 has been keeping the medication in R107's bedside table since admission into the facility about 3 months ago. On [DATE] at 3:13 PM, V18 (Registered Nurse/RN) acknowledged the medications, V18 stated V18 gave Jardiance 1 tablet 10mg to R107 today at 9:00 AM,.V18 stated the medications should not be at the bedside. V18 took the Ibuprofen medications from the bedside for proper storage. V18 stated R107 can overdose on Metformin and Jardiance, which can potentially lead to hypoglycemia, and R107 can overdose on Ibuprofen, which can result in inflammation and bleeding. On [DATE] at 3:16 PM, V26 (RN-Supervisor) stated R107 is known for keeping medications at the bedside. V26 stated nurses should supervise R107 to prevent R107 from keeping medication at bedside. V26 stated R107 can potentially overdose on the Ibuprofen which could affect the liver and possibly cause R107 to bleed. V26 will educate R107 on the risk and complication and assess R107 for self-administration of medication. V26 will educate nurses to supervise and constantly check on R107 and all residents to prevent unauthorized medication at bed side. On [DATE] at 3:30 PM, V2 (Director of Nursing/DON) stated if there is no doctor's order for self-administration of medication, R107 should not keep medication at bedside. Nurses should supervise to ensure R107's medication is not kept at bedside. R107's Minimum Data Set (MDS), dated [DATE], shows R107 is cognitively intact. R107's Physician Order Sheet (POS) with active orders as of [DATE] shows an order for Jardiance oral tablet, to give 1 tablet daily. And metformin HCL oral tablet 1000mg, give I tablet by mouth every 12 hours. R107's clinical records had no documentation showing R107 is safe to administer R107's own medications. A review of R107's clinical records do not show a self-administration of medication assessment was completed. The facility's policy for Self-Administration of medication dated ,d+[DATE] reads in part: Only the medications permitted for self-administration shall be left at the bedside. A self-administration of medications assessment will be completed that indicates that the resident is capable of self-administering drugs.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46342 Based on observation, interview, and record review, the facility failed to follow resident's food allergy and food preferences. This failure affected 1 (R143) out of 3 residents reviewed for nutrition in a sample of 34. Findings include: R143's diagnosis included but not limited to End Stage Renal Disease, Dependence on Renal Dialysis, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Acute on Chronic Systolic (Congestive) Heart Failure, Unspecified Glaucoma, Abnormalities Of Gait And Mobility, Abnormal Posture, Unsteadiness On Feet, Sensorineural Hearing Loss Bilateral, Anemia In Chronic Kidney Disease, Insomnia, and Constipation. R143's Order Summary Report dated 06/05/24 documents in part Allergies: Eggs. R143's nutrition care plan, dated 04/11/24, documents in part, allergy: eggs R143's MDS (Minimum Data Set) from 05/09/24 BIMS (Brief Interview for Mental Status) score is 15 out of 15, indicating intact cognition. R143's Dietary Profile, dated 04/12/24, by V5 (Diet Tech) documents R143 allergies: eggs. R143's Dietitian Evaluation, dated 05/06/24, by V33 (Registered Dietitian) documents allergy to eggs. R143's breakfast/lunch/supper meal tickets indicate Allergies: eggs and dislikes include coffee, eggs, citrus, to add yogurt and serve (cereal name) or grits. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/24 at 10:12 AM, R143's breakfast tray was on over the bed table in front of R143. On R143's tray was 1 slice of cinnamon toast, 1 scoop of scrambled eggs, bowl of hot cereal, 2% milk carton, 4 oz. apple juice. Observed R143's meal ticket which listed Allergies: Egg. Dislikes: Citrus, Coffee, Eggs. Notes: Raisin Bran/Grits, 2% milk, wheat bread, add yogurt, give biscuit + gravy when on menu, 2% milk, apple juice, give pepper + butter. Diet = Renal, Dental Soft (Mechanical Soft). Observed empty 2% milk carton on R143's tray. R143 consumed 0% of cinnamon toast, 0% scrambled eggs, 0% hot cereal. R143 stated, I don't eat toast in the morning and I'm allergic to eggs. R143 stated as a child, R143 would break out in hives after eating eggs. R143 said, I haven't eaten eggs my whole life. R143 stated R143 can eat eggs if they are an ingredient in something like cake, but cannot eat them when they are served alone. R143 stated the hot cereal served to R143 was (cereal name), and R143 won't eat that. R143 stated the only hot cereal R143 will eat is grits. R143 stated R143 loves cold cereal and if they had given R143 cold cereal this morning R143 would have eaten that. R143 stated R143 only drank the milk this morning for breakfast because it is the only thing on the tray that R143 liked. R143 stated If they give R143 food R143 does not like or eggs (allergic to) then R143 just doesn't eat it. R143 stated R143 does not ask for something else to eat. R143 stated he likes to drink coffee and does not know why it is listed on R143's meal ticket as a dislike. R143 said, I don't eat yogurt because when I was in the service the white soldiers used to spit in the yogurt for the black soldiers so since then I've never eaten yogurt and I never will. Even if the yogurt is vacuumed sealed, I won't eat it. I have that same image of the white soldiers spitting in it. On 06/06/24 at 8:02 AM, V33 (Registered Dietitian) stated food allergies and preferences are obtained upon admission and documented on the kitchen's computer system which then generates a meal ticket. V33 stated the resident's food allergy and/or food preferences are listed on the resident's meal ticket, which is how the kitchen staff would know what the resident is allergic to and what their food preferences are. V33 stated it is important for the kitchen staff to follow the meal tickets to minimize the risk of a resident receiving something they are allergic to and having an allergic reaction to it. V33 stated it is also important to follow the meal tickets for resident food preferences to ensure the residents will eat their food. V33 stated if residents do not like the food received, they may not eat the food which could cause a weight loss. V33 viewed R143's breakfast meal ticket from 06/04/24 and stated R143 is allergic to eggs, and should not have received eggs. V33 stated if R143 ate the eggs, R143 could have had an allergic reaction possibly requiring hospitalization . V33 stated based on R143's meal ticket, R143 does not like to drink coffee or citrus items, but does like (name brand) cereal or grits and likes yogurt and wheat toast. V33 stated the meal tickets should reflect R143's actual food preferences. V33 stated based on the information R143 provided to the surveyor about liking coffee and any type of cold cereal but not liking yogurt, or toast R143's food preferences need to be reviewed and updated to reflect R143's actual likes/dislikes. On 06/06/24 at 8:23 AM, V35 (Food Service Director) stated R143 receiving eggs for breakfast on 06/04/24 was a mistake. V35 stated R143 should not have had eggs on R143's tray because R143's meal ticket says R143 is allergic to eggs and the kitchen staff should be reading/following the meal ticket. V35 stated (cereal name) was the hot cereal served to all the residents for breakfast on 06/04/24 and based on R143's meal ticket R143 should have received Raisin Bran or grits. Facility provided policy titled Meal Identification and Preference Cards/Tickets undated, documents: 1.) A meal identification and food preferences card will be used to properly identify each individual's needs including food and beverage preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) The director of food and nutrition services or designee will visit a newly admitted individual to obtain food and fluid preferences, dislikes, and food allergies/intolerances. 3.) Meal ID cards/tickets will be used during meal service to assure the correct diet is being served and food preferences honored.

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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. 44103 Based on observation, interview, and record review, the facility failed to ensure food in the main cooler was discarded after the used by date, and failed to ensure frozen meat products were dated inside the main freezer. This failure has the potential to affect 122 residents in the facility who are receiving oral diet. Findings include: On 6/04/24 at 9:01 AM, during the initial kitchen tour with V35 (Food Service Director), a container of grape jelly was found in the main cooler with the label that shows prepared on 3/29 and use by 4/31. A pack of frozen sausages and a pack of frozen meat with no labelled dates were found in the freezer. At 09:28 AM, V35 stated all foods stored in the coolers and freezer are supposed to be dated so kitchen staff knows what to take first. V35 stated staff follows the first in and first out policy. V35 stated prepared foods are supposed to be dated when it was prepared and the discard date. V35 stated foods should be discarded on the Use By date for food safety. The facility's policy titled; Food Storage with no date documents: All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. Old stock is always used first (first in - first out or FIFO). The person designated to manage stock should be trained to rotate it properly. Food should be dated as it is placed on the shelves if required by state regulation. Date marking should be visible on all high risk food to indicate the date by which a ready-to-eat TCS food should be consumed, sold or discarded. The facility's policy titled; Food Temperatures with no date documents: Refrigerated food storage: All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. Frozen Foods: All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use dates or discarded. The facility's roster documents 161 residents residing in the facility with 39 residents who are NPO (Nothing By Mouth).

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review, the facility failed to label and date food items in resident personal refrigerator; failed to monitor and document personal refrigerator temperatures daily to ensure temperature is maintained at or below 41 degrees F (Fahrenheit) for safe food storage; failed to discard unlabeled/undated food or foods whose date is outside facility food storage policy of three days; and failed to clean personal refrigerators regularly to maintain a safe and sanitary environment for food storage. This has the potential to effect 4 residents (R23, R97, R105, R164) out of 7 residents reviewed for personal food storage in a total sample of 34. Findings include: 1. R105's diagnoses includes but not limited to Cerebral Vascular Disease, Cerebral Aneurysm Non-Ruptured, Unspecified Protein Calorie Malnutrition, Abnormalities of Gait and Mobility, Glaucoma, Unspecified Cataract, Other Visual Disturbances, and Adult Failure to Thrive. R105's Order Summary Report, dated [DATE], documents in part General Diet Regular texture, thin consistency. R105's MDS (Minimum Data Set), dated [DATE], indicated impaired vision, and BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating intact cognition. R105's Refrigerator Temperature Log dated with temperatures between [DATE] to [DATE] documents in part on on [DATE] temperature 36, [DATE] temperature 36, [DATE] temperature 39, [DATE] temperature 39, [DATE] temperature 37. There were no temperatures logged for the month of May or June. On [DATE] at 11:08 AM, observed personal refrigerator in R105's room. R105 stated R105's son brings her food which R105 keeps in R105's refrigerator. R105 gave surveyor permission to look inside R105's refrigerator. Observed unopened 8-ounce carton of 2% milk, dated best by [DATE]; opened 16-ounce package of [NAME] Sausage which was not labeled/dated and was ,d+[DATE] full of a layer of ice with hard brown/yellow sticky material surrounding the salami; and opened 8 ounce package of Beef Bologna which was not labeled/dated and was covered in a white milky liquid. Observed the inside of R105's refrigerator with hard encrusted food on the bottom shelf, red stains along the left side of the refrigerator and speckled greenish brown dots inside the door. Observed piece of paper titled Refrigerator Temperature Log posted outside R105's refrigerator door. The last documented date/time was [DATE] and temperature was 37 degrees. On [DATE] at 11:12 AM, R105 said, My eyesight isn't good. I can't see well. R105 stated the date on the milk carton is too small for her to see, and R105 did not notice the salami and bologna had gone bad. R105 said, You can throw them out if you think they need to be put in the trash. (continued on next page)

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

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:19 AM, V11 (Certified Nursing Assistant) inspected visually the [NAME] Salami, Beef Bologna, milk carton dated [DATE], and stated, The milk has expired and the meat looks bad. (R105) could get sick if (R105) ate those items. V11 looked inside R105 refrigerator and stated it looked like juice had spilled inside it, and overall, the refrigerator looked like it needed to be cleaned. V11 stated the CNAs are not responsible for cleaning the refrigerators or taking the temperatures of the refrigerators or labeling/dating the items inside the refrigerator. On [DATE] at 11:26 AM, V12 (Housekeeper) stated V12 cleans the resident's personal refrigerators every , d+[DATE] weeks and as needed. V12 stated V12 does not check temperature of the refrigerators or if the items are labeled/dated. V12 stated if a food item looks spoiled, V12 would throw it out. V12 viewed the milk carton, dated [DATE], and stated it is not good because it is past the expiration date. V12 viewed the salami and bologna and stated it all looks bad, and should be thrown out because it could make R1105 sick if R105 ate them. 2. R164's diagnoses includes but not limited to aftercare following Joint Replacement Surgery, Presence of Right Artificial Knee Joint, Rheumatoid Arthritis, Enterocolitis Due To Clostridium Difficile Not Specified As Recurrent, Viral Hepatitis B without Hepatic Coma, Type 2 Diabetes Mellitus without Complications, Unspecified Protein Calorie Malnutrition, Dysphasia Oropharyngeal Phase, Urinary Tract Infection, Cognitive Communication Deficit, Parkinson's Disease, Hypertension, and Hyperlipidemia. R164's Order Summary Report, dated [DATE], documents General Diet, regular texture, thin consistency. R164's MDS (Minimum Data Set), dated [DATE], BIMS (Brief Interview for Mental Status) was 15 out of 15 indicating intact cognition. R164's Refrigerator Temperature Log dated with temperatures between [DATE] to [DATE] documents in part on on [DATE] temperature 36, [DATE] temperature 36, [DATE] temperature 39, [DATE] temperature 39, [DATE] temperature 37. There were no temperatures logged for the month of May or June. On [DATE] at 11:54 AM, observed personal refrigerator in R164's room. R164 stated R164's family brings her food which R164 keeps in R164's refrigerator. R164 gave surveyor permission to look inside R164's refrigerator. Observed unopened 8-ounce cartons of milk (1% carton best by date [DATE], 2% carton best by date [DATE], 2% carton bed by date [DATE]); two large potatoes in a plastic bag (not labeled or dated); container of cooked cabbage (not labeled or dated) and light brown sauce with chunks of tofu in it (not labeled or dated). Observed piece of paper titled Refrigerator Temperature Log posted outside R164's refrigerator door. The last documented date/time was [DATE] and temperature was 37 degrees. On [DATE] at 12:00 PM, V10 (Licensed Practical Nurse) observed milk cartons dated [DATE], [DATE], [DATE] and stated, The milks have expired and (R164) should not drink them. V10 stated V10 does not know how long the unlabeled/undated items (potatoes, cooked cabbage, tofu containing sauce) have been in R164's refrigerator because they are not dated. V10 stated the potential problem is the R164 could get sick if R164 consumed spoiled items. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R97's diagnoses includes but not limited to Heart Failure, Hypertensive Heart Disease with Heart Failure, Asthma, Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Insomnia, Chronic Pain, Hyperlipidemia, and Anemia. R97's Order Summary Report, dated [DATE], documents No Added Salt Diet Regular texture, thin consistency, NO PORK. R97's MDS (Minimum Data Set), dated [DATE], BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating intact cognition. R97's Refrigerator Temperature Log dated with temperatures between [DATE] to [DATE] documents in part on on [DATE] temperature 36, [DATE] temperature 36, [DATE] temperature 39, [DATE] temperature 39, [DATE] temperature 37. There were no temperatures logged for the month of May or June. On [DATE] at 12:14 PM, observed personal refrigerator in R97's room. R97 gave surveyor permission to look inside R97's refrigerator. Observed container of rice and fried chicken not labeled or dated. Observed piece of paper titled Refrigerator Temperature Log posted outside R97's refrigerator door. The last documented date/time was [DATE] and temperature was 37 degrees. On [DATE] at 12:15 PM, R97 stated R97 has not seen anyone check the temperature of R97's refrigerator in a while. On [DATE] at 12:18 PM, V10 reviewed R97, R105, R164's Refrigerator Temperature Logs and stated all the dates and temperatures look exactly the same on all three logs. On [DATE] at 11:33 AM, V21 (Director of Environmental Services) stated V21 oversees the Maintenance and Housekeeping departments. V21 stated Housekeeping should be monitoring the resident personal refrigerators and cleaning them as needed, and throwing out food items that look old or spoiled. V21 stated food items in the resident personal refrigerators should be labeled/dated, but that is not Maintenance or Housekeeping responsibility. V21 does not know who is responsible for labeling/dating items. V21 stated it is important to monitor resident's personal refrigerator temperatures to make sure the refrigerator is working properly to keep the food from spoiling. V21 was shown R97, R105, R164's Refrigerator Temperature Logs, and stated all the dates and temperatures were in the same handwriting and look the same on all three logs. V21 stated there should be separate entries for each resident's refrigerator, not the same for everyone. V21 stated V21 does not think it is possible for each of those 3 residents to have the exact same refrigerator temperatures on the same day. V21 said, It almost seems like they were photocopied. On [DATE] at 8:20 AM, V33 (Registered Dietitian) stated food items in resident personal refrigerators should be labeled and dated so the staff knows when the item was put in there and when it needs to be thrown out. V33 stated food items could go bad and if a resident was to consume the item there is a risk it could make the resident sick. V33 stated milk dated ,d+[DATE] is not safe for a resident to drink, and could cause a food borne illness if consumed. V33 stated the personal refrigerators should be 41 degrees or below, and it is important for the temperatures to be monitored to make sure the food is being stored in the correct temperature zone so the food does not go bad. Facility provided policy titled, Food Brought in from Outside Sources and Personal Food Storage, dated 2023, documents (continued on next page)

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Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) Food brought to the facility by family members or friends will be handled using safe food handling guidelines. Designated staff should monitor foods and beverages brought in from outside sources for storage in personal room refrigerator units. 2.) Designated facility staff should be assigned to monitor individual room storage and refrigeration units for food or beverage disposal. 3.) All refrigeration units will have internal thermometers to monitor for safety food storage and temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperatures. 50057 4. On [DATE] at 9:58 AM, a personal refrigerator was observed in R23's room. The Refrigerator Temperature Log on the front door of the refrigerator documented that the temperature was last checked on [DATE]. In addition, there was no temperature reading for [DATE], there was a documented reading or February 30, 2024 which was not a date on the 2024 calendar, and there was no temperature reading for [DATE]. Inside of the refrigerator there appeared to be a piece of fried chicken that was wrapped in a white paper napkin. Food was observed in a plastic container with no label or description and no use by date, and a pint carton of milk was observed to have had an expiration date of [DATE]. On [DATE] at 9:05 AM, a [DATE] Refrigerator Temperature Log for R23 was observed on the refrigerator door. There were no temperatures recorded for [DATE], [DATE] or [DATE]. On [DATE] at 10:06 AM, V2 (Director of Nursing) stated Maintenance staff performs daily checks of residents' personal refrigerator temperatures. Maintenance staff also checks food in the refrigerators every 72 hours to make sure that nothing is expired. V2 stated the expiration date on the milk in R23's refrigerator was [DATE]. V2 also described what looked like fried chicken wrapped in a napkin, and V2 described food in a plastic container with no date. There was no thermometer in the refrigerator. V2 stated perhaps the Maintenance department uses an external portable thermometer. When asked why refrigerator temperature checks and food expiration dates are important, V2 stated, I mean, food poisoning. When R23 asked V2 if everything was ok, V2 responded, Everything is not ok. Policy titled Refrigerators in Resident's Rooms, dated 2020, stated: Guideline: Resident and/or responsible party will agree to allow periodic safety checks by staff and allow staff to discard outdated food per safety guidelines. Procedure: 2. Each refrigerator shall have a temperature log with daily entry. Each refrigerator will have an inside thermometer. The refrigerator temperature will be maintained at or below 41 degrees Fahrenheit. If the temperature is not maintained at 41 degrees Fahrenheit or below, the food will be discarded. 3. The housekeeper will enter the temperature once daily. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. All food in the refrigerator will be labeled with the common name and the use by date. 6. All food will be monitored when daily temperature check is performed. Any food item past its use by date will be discarded by staff or resident. The resident and/or the resident's responsible party will be educated on food safety and left over food will be discarded after three days. 9. Housekeeping supervisor will conduct at least monthly quality assurance audit of refrigerators to monitor adherence to procedure.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40061 Based on interview and record review, the facility failed to ensure accurate medical records for one (R148) out of a total sample of 34 residents. Findings include: R148's Admission Record documents in part medical diagnosis of adult failure to thrive. Dietary progress note, dated 3/21/2024 9:10 AM, documents, secondary to significant weight loss, writer recommends increasing House Supplement 1 carton to [three times a day] to promote additional [kilocalorie] and protein for weight maintenance or gain. R148's Order Summary Report documents an active order for House Supplement three times a day 1 carton for supplementation (ordered 3/21/2024). R148's Care Plan documents in part an intervention initiated on 3/22/2024 for house supplement one carton three times a day. On 6/04/2024 at 11:10 AM, R148 was alert and oriented to person and place. R148 stated R148 was hungry and R148 was asking about food. At 12:23 PM, R148 was eating lunch. Lunch tray had chili dog, green beans, sweet potato, banana pudding, apple juice, and 2% milk. Surveyor asked if facility provides nutritional shakes. R148 shook head no. At 12:27 PM, surveyor asked V6 (Nurse) if R148 receives a house supplement. V6 initially stated yes, and started naming vitamin pills. Surveyor clarified house supplement and not oral pills. V6 then pointed to critical care supplement. Surveyor asked if that is what R148's physician order is referring to. V3 (Assistant Director of Nursing) who was also at the nurses' station spoke up and stated they will look at the order together. V3 and V6 reviewed R148's physician orders on the computer. V6 stated it was a special order that came from downstairs. V3 and V6 stated Dietary brought up the house supplements. V3 stated, It isn't kept on the floor, and Dietary will bring it up with the meals or bring it up in between meals. V3 stated according to the orders, R148 should receive it three times a day. At 12:37 PM, V4 (Cook) stated nurses supply the house supplement to the residents, not the kitchen. At 12:43 PM, V5 (Diet Tech) stated nurses give the house supplement to the residents, not kitchen. V5 reviewed R148's orders in the electronic medical record. V5 stated, Yup, [R148] is supposed to get it three times a week. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:59 PM, V9 (Central Supply Coordinator) stated the facility has multiple types of house supplements in stock. Surveyor observed at least three different nutritional supplement shakes in the supply room. When asked if R148 receives house supplement, V9 stated R148's name was not familiar and doesn't recall any nurse requesting for house supplement for R148. V9 stated usually the nurses will inform V9 if there's a need for house supplement and V9 will send a box up. If needed the nurses or certified nurse aides can come downstairs and retrieve a box of supplements. At 2:29 PM, surveyor reviewed R148's May 2024 Medication Administration Record (MAR) with V6 at the nurses' station. V6 stated initials for 5/01, 5/02 and 5/04 belonged to V6. Surveyor asked what V6 charted as administered for the house supplements. V6 stated Dietary provides it. Informed V6 of interview with V4 and V5. V6 stated, I don't have it. V6 stated V6 didn't administer the house supplements. V6 stated, That was my mistake. V3 asked V6, Are you saying you are not giving it? V6 stated, I don't have it. We don't keep it on the floor. I don't give it. Reviewed April MAR. There were multiple entries V6 charted as administering the house supplements. On 6/06/2024 at 11:16 AM, V3 stated the expectation is for staff to document accurately. They are expected to document whatever they do or don't do. Facility's undated Medical Records policy documents: Medical Records must be accurately documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review, the facility failed to provide Enhanced Barrier Precautions while providing wound care to 1 (R137) resident; failed to post Enhanced Barrier Precautions (EBP) signage and have Personal Protective Equipment bin outside 1 (R93's room); and failed to provide enhanced barrier precautions to 1 (R143) resident with an indwelling medical device. This has the potential to affect all residents living in the facility. Findings Include: 1. R137's Face Sheet shows R137 is a [AGE] year-old, with Brief Interview for Mental Status (BIMS) score of 0 (05/11/24), which means R137 is cognitively impaired. Physician Order Sheet shows R137's diagnoses include Acute and Chronic Respiratory Failure with Hypoxia, Dependence on Renal Dialysis, Dependence on Respirator Ventilator Status, Encounter for Attention to Gastrostomy, and Chronic Pressure Wound. Signage posted on R137's door reads in part: Wear gloves and a gown for the following high-contact resident care activities: Wound Care: any skin opening requiring a dressing. On 06/04/24 at 11:43 AM, =V25 (Wound Care Nurse) was in R137's room providing wound care to R137, and V25 was not wearing a protective gown. V25 stated V25 should have worn a gown as posted by R137's door. Surveyor asked V25 what could be the potential harm to R137 and other residents? V25 stated the potential harm to R137 and other residents is contamination and transmission of infection. On 06/04/24 at 11:50 AM, V16 (Infection Prevention Director) stated it is V16's expectation staff will comply with the instructions as posted by R137's door to prevent transmission of infection. V16 stated any staff performing any direct contact care, like wound care, central line, feeding tube, tracheostomy, and toileting care should wash hand, wear gloves, and wear a gown. V25 should have worn a gown before providing wound care for R137 to prevent transmission of infection by V25. V16 stated indwelling catheter should be in a privacy bag when in use and not on the floor. On 06/06/24 at 2:31 PM, surveyor asked V36 (Wound Care Nurse) if V36, V25, and other wound care nurses provide only wound care? V36 stated, No! the wound care nurses provide other care like answering call lights and assist with transferring when on the floor not just only wound care. V36 stated V25 works on different floor, and V36 just provided shower for a resident on the floor before coming to speak with the surveyor. The facility policy titled Enhanced Barrier Precaution (EBP), dated 1/15/24, documents: Any situation where expected contact of blood, bodily fluids, skin breakdown, or mucous membranes will be encountered. Personal Protective Equipment (EPP) required: Gowns and Gloves. 40061 2. R93's Admission Record documents pressure ulcer of sacral region, stage 4. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R93's Order Summary Report documents multiple orders for wound care. R93's electronic medical record's screen documents Enhanced Barrier Precautions under Special Instructions. R93's care plan documents R93 has skin stripping to left groin and right grown. It also documents R93 has pressure injury to sacrum, right trochanter, right posterior hip, left trochanter, right knee, right lower leg, left lateral lower abdomen, and left knee. R93's care plan documents special instructions for Enhanced Barrier Precaution. On 6/04/2024 at 10:52 AM, there was a written sign on R93's door that documents: please put on face mask before entering per resident request. No other precautionary sign indicating Enhanced Barrier Precautions. At 11:07 AM, V6 (Nurse) stated R93 was not on isolation or special precautions. V6 stated, Only standard and put on gloves. Facility's Enhanced Barrier Precautions (EBP) policy, last updated 4/01/24, documents: Purpose: To minimize the risk of acquiring, transmitting, or complications resulting from multi-drug resistant organism (MDRO) colonization among residents in this setting. Populations affected include residents at increased risk of MDRO acquisition (Residents with wounds or indwelling medical devices). Guidelines: Resident will require the use of personal protective equipment (PPE) for high-risk activities such as: bathing, dressing, toileting, transferring residents, linen changes, wound care, handling indwelling medical devices, any situation where expected contact of blood, bodily fluids, skin breakdown, or mucous membranes will be encountered. 46342 3. R143's diagnoses included but not limited to End Stage Renal Disease, Dependence on Renal Dialysis, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Acute on Chronic Systolic (Congestive) Heart Failure, Unspecified Glaucoma, Abnormalities Of Gait And Mobility, Abnormal Posture, Unsteadiness On Feet, Sensorineural Hearing Loss Bilateral, Anemia In Chronic Kidney Disease, Insomnia, and Constipation. R143's Order Summary Report, dated 06/05/24, documents dialysis access device: venous access device location right femoral dated 04/10/24 and dialysis schedule Tues-Thurs-Sat dated 04/10/24. R143's MDS (Minimum Data Set) from 05/09/24 BIMS (Brief Interview for Mental Status) score is 15 out of 15, indicating intact cognition, receiving hemodialysis, and requires substantial/maximal assistance with toileting hygiene, and partial/moderate assistance with showering/bathing self. On 06/04/24 at 10:10 AM, surveyor did not observe a sign outside R143's room posted for Enhanced Barrier Precautions (EBP), and did not observe a personal protective equipment (PPE) container outside R143's room. On 06/04/24 at 10:11 AM, R143 stated R143 gets hemodialysis three times a week in the basement at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/04/24 at 2:17 PM, conducted second observation. Did not observe a EPB sign posted outside R143's room. On 06/04/24 at 2:25 PM, V10 (Licensed Practical Nurse) reviewed R143's electronic health record (EHR) and said, He gets hemodialysis via right femoral access. On 06/04/24 at 2:27 PM, reviewed R143's EHR and did not find any orders or care plan in place for EBP. On 06/04/24 at 2:35 PM, V16 (Infection Prevention Director/Licensed Practical Nurse) stated residents with a multi-drug resistant organism (MDRO) and/or residents with any indwelling lines/tubes/drain, including anyone with a dialysis access site, are placed on EBP as a precaution. V16 stated dialysis access line is a large bore access which can increase the incidence of getting an infection, which is why it is important that staff increase hand hygiene and don PPE when providing care to these residents to reduce the risk of infection. V16 stated EBP signage is placed outside resident doors to provide a visual notification to the staff and provides instructions on what visitors/staff should do before entering the room. V16 stated the purpose of the EBP signage is to alert staff to do hand hygiene and wear PPE before providing direct care and visitors to do hand hygiene before and after entering the room and if there is no EBP sign out the resident's room there is the risk the staff will not know to don PPE before providing care. V16 stated if a resident is on EBP it would be documented in the resident's EHR under special instructions section. On 06/04/24 at 2:40 PM, V16 stated if R143 is receiving dialysis, then R143 should be on EBP. R143's EHR documented Standard Precautions was written under the special instructions section. V16 stated, In the special instructions section it should be listed as EBP, not Standard Precautions because (R143) has a right femoral access. On 06/04/24 at 2:42 PM, V16 walked with surveyor to R143's room. V16 viewed R143's door and said, No, there is not a EBP sign on his door, but there should be. Facility provided policy titled Enhanced Barrier Precautions (EBP), dated 01/15/24, which documents staff will require the use of personal protective equipment (PPE) for high-risk activities such as bathing, toileting, and handling indwelling medical devices and persons expected to encounter these circumstances are to don PPE (gown and gloves) in accordance with the activity that will be encountered when caring for the resident.