STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care North Branch	6840 West Touhy Avenue Niles, IL 60714

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interviews and record review, the facility failed to notify and inform a resident's primary care physician (PCP) of the onset of a resident's elevated heart rate, interventions of a nurse practitioner and respiratory therapist not directly under the PCP, and continued changes of condition, including but not limited to abnormal labs for a resident within a timely manner. This applies to 1 resident ([R1]) in the sample. Findings include: According to the Facesheet, [R1] was a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Acute and Chronic Respiratory Failure with Hypoxia; Tracheostomy; Spastic Quadriplegic Cerebral Palsy; Seizures; Encounter for Attention to Gastrostomy; Myoneural Disorder; and Unspecified Intellectual Disabilities. [R1]'s care plan dated 06/13/2024 reads in part, [R1] has a Tracheostomy s/p acute and chronic respiratory failure with hypoxia. Interventions: Monitor for signs/symptoms of respiratory distress (restlessness, agitation, confusion, increased heart rate (Tachycardia), air hunger, and/or bradycardia; Monitor level of consciousness, mental status, and lethargy PRN; Monitor respiratory rate, depth, and quality (work of breathing), Check and document every shift/as ordered. Resident has potential for alteration in respiratory functioning related to acute and chronic respiratory failure with hypoxia s/p tracheostomy. Interventions: Assess respiratory status, observe for shortness of breath, monitor lung sounds. Call physician for any changes in condition and as needed; Call physician for any changes in condition. [R1]'s vital sign as documented for 06/14/2024 timeline: 00:46 (12:46 AM) - HR 105 beats per minute 3:20 AM - HR 151 beats per minute 9:11 AM - HR 148 beats per minute 11:07 AM - HR 120 beats per minute 11:23 AM - HR 148 beats per minute (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:15 PM - HR 160 beats per minute, RR 44 breaths per minute - [R1] placed on the ventilator. 3:23 PM - WBC was 22.71- V16 (PCP) notified, no new orders. 3:40 PM - HR 153 beats per minute 4:45 PM - HR 130 beats per minute - no interventions 4:57 PM - HR 130 beats per minute 5:44 PM - HR 147 beats per minute 5:59 PM - HR 145-150 beats per minute - V16 (PCP) notified; orders received to send [R1] to the hospital. 7:20 PM - HR 153 beats per minute [R1]'s record indicated facility staff did not contact V16 for 14 hours (12:46AM-3:23PM) past the onset of [R1]'s elevated heart rate. [R1]'s progress note written by V17 (Respiratory Therapist/ RT Director) dated 06/14/2024 3:23 PM reads in part, (At) 1515 ([R1]) abnormal (vital signs) in respiratory distress, HR 160 RR >35bpm (44) sat 91-93% on TC 40%. ([R1]) w/ small yellow thick secretions. (Airway) patent, fio2 increased to 50%. WBC was 22.71 today, (V16 PCP) notified. (V15 Pulmonary NP) notified, x-ray ordered. Pending results. ([R1]) will be placed on vent full support to prevent respiratory failure w/ settings AC 16 300 +5 40% per (V15). Will notify POA. [R1]'s progress note written by V15 (Pulmonary Nurse Practitioner) dated 06/14/2024 3:30 PM reads in part, Notified by (respiratory therapy) that ([R1]) for consult to be seen by our service on 7/14 08:48am. Notified that ([R1]) on continuous (tracheostomy collar) at 40% and had a 7 TTS trach in place. Then was notified by (respiratory therapy) at (3:20 PM) that ([R1]) had developed increased work of breathing, tachypnea with counted RR 52, HR 150s and sats in low 90s. ([R1]) was given (heart rate lowering medication), cardiology consulted, and ([R1]) had WBC 22 (22,000). ([R1]) placed on mechanical ventilation. Reviewed (electronic medical record) and gave order for sputum (culture) and empiric (antibiotic). (Chest x-ray) on 6/14: There is patchy right hilar and basilar density suspicious for pneumonia. [R1]'s lab order dated 06/12/2024 at 10:32 PM reads in part, Priority: Routine. CBC with Diff, Comprehensive Metabolic Panel, Lipid Panel w/reflex to direct LDL, Thyroid Stimuli Hormone, Hemoglobin A1C. Ordering physician: (V24 Admitting Physician). [R1]'s routine blood work collected 06/14/2024 at 5:35 AM, results posted on 06/14/2024 at 10:23 PM. WBC (White Blood Cells) 22.71 H (high) (reference range 3.4-10.8). (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/2024 at 12:39 PM V7 (Respiratory Therapy Director) stated in part: [R1] was admitted to the facility on [DATE]. [R1]'s initial oxygenation orders were for tracheostomy collar 40% fio2 (5 liters per minute, fraction of inspired oxygen). [R1] was stable on those settings on 06/12/2024 and 06/13/2024. Around 9:00 AM on 06/14/2024 V7 was notified by V9 (Respiratory Therapist) that [R1] developed tachycardia (elevated heart rate) but had clear airway and appropriate oxygen saturation level. [R1]'s respiratory rate was into mid 20 breaths per minute, but it was not critical. V7 stated, I assessed [R1] at that time, and, following my assessment, I notified nurse on duty (V8 - Registered Nurse) and V15 (Pulmonary Nurse Practitioner). We are required to notify nurse on duty and pulmonary physician if we notice any resident change in condition. I was concerned with [R1's] tachycardia. There were no new orders from respiratory side at that time, just to closely monitor. Around 3.15 PM, [R1] was in distress. [R1's] heart rate was in 150's bpm (beats per minute), respiratory rate was over 35 breaths per minute, rapid and shallow, and oxygen saturation was 88-89% on tracheostomy collar. I immediately notified V15 (Pulmonary NP) and I received orders to place [[R1]] on ventilator to prevent respiratory failure. Right when, I placed [R1] on the ventilator. I notified V19 [R1]'s family member) via phone, explained reasons behind putting [R1] on ventilator, and I also assured her that I will make sure [R1] has a private room. On 07/01/2024 at 9:45 AM V13 (Admitting Nurse Practitioner) stated: I did not physically see [R1] on 06/14/2024; however, I admitted him on 06/13/2024, and I was most familiar with [R1] when nurses called to notify about [R1]'s elevated heart rate. I'm in the facility on daily basis and it is easiest to reach me out of most medical staff. I confirmed that it is ok to give [R1] scheduled dose of medication to lower [R1]'s heart rate at 9:00 AM after receiving previous dose of the same medication earlier that morning. I was also waiting for routine blood test to come back that I ordered upon [R1]'s admission (on 06/12/2024). I also asked if [R1] is being followed by a cardiologist. Considering [R1] was treated for pneumonia prior to coming to the facility and being new to tracheotomy, I wasn't overly concerned with his tachycardia. I would become more concerned if [R1] developed additional symptoms, the rule of thumb is that, at least three elements of vital signs are abnormal, it might be an infection or sepsis, and it is appropriate then to send a resident out to the hospital. Knowing that his white blood cells level was elevated (to 22,000) in additional to tachycardia, I would definitely send him out to the hospital; however, I was gone (around 11:30 AM) by the time those blood work results came back. On 7/1/2024 at 4:10 PM V17 (Director of Nursing) stated in part: I believe V15 (Pulmonary Nurse Practitioner) was on [R1]'s case and [R1]'s primary driver was his respiratory status; therefore, V16 (Primary Care Physician/PCP) was not notified until 5:59 PM. At the time of [R1]'s distress, around 3:30 PM, when his heart rate was in 160's (beats per minute), respiratory rate in 40s (breaths per minute), and white blood cell level results were known to be elevated, V15 (Pulmonary NP) already placed an order for a ventilator. V16 (PCP) was notified at 5:59 PM when all respiratory and cardiac interventions were exhausted. [R1]'s chest x-ray didn't result until the morning of 06/15/2025, and blood work started posting in the laboratory portal in the early afternoon of 06/14/2024. CBC (Complete Blood Count) is prioritized, so it was most likely posted as a partial result first and that's how nurses were aware of [R1]'s elevated white blood cell level before 10:23 PM when the rest of [R1]'s blood work results were available. [R1] was a hard stick, his blood sample was not collected until the morning of 06/14/2024, even though the order was placed on 06/12/2024. Our laboratory doesn't notify us of any abnormal lab results, so it is up to the nurses to follow up on them. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 1:05 PM V8 (Registered Nurse) stated: I didn't notify V16 (PCP) of [R1]'s change of condition on the morning of 06/14/2024 because I wasn't aware of change of primary physician for [R1]. [R1] was assigned to another primary physician when he was initially admitted on [DATE] and then it was changed. Besides, V13 (Admitting Nurse Practitioner) was on site and was aware of [R1]'s elevated heart rate from previous night, so I just asked her for orders. Later that day (06/14/2024), I called around 11:00 AM and spoke to V16 (PCP). I told him about [R1]'s elevated heart rate, confirmed that he wasn't in any distress, and verified that [R1] had his blood drawn in the morning and results are still pending. V16 told me to monitor [R1] and notify him of blood work results. I checked for [R1]'s blood work results around 1:15 PM, and they were not posted at that time. I didn't talk to V16 (PCP) again before the end of my shift. Another test for [R1] that was ordered during my shift, was STAT chest x-ray, but I don't remember it being done. On 07/01/2024 at 10:59 AM V15 (Pulmonary Nurse Practitioner) stated: On 06/14/2024 at 8:48 AM, I was notified that there was a new resident that I was consulted for. Even though, [R1] was admitted on the evening of 06/12/2024. I've never seen [R1] face to face, it is pretty typical though. V7 (RT Director) told me that [R1] was admitted with tracheostomy collar, verified orders for the tracheostomy with me, and that was it. Nothing unusual at that point. Later that day, at 3:20 PM, I was notified that [R1] had increased respiratory rate, to over 40 breaths per minute. V7 (RT Director) actually said that [R1]'s respiratory rate was 52 breaths per minute at that time, heart rate was in 150's bpm (beats per minute), his oxygen saturation level in the low 90%, and he was breathing shallow, all of which would tell me, [R1] was in acute respiratory distress. V7 (RT Director) asked for an order to put [R1] on the ventilator and for ventilator settings. Given [R1]'s condition, placing him on the ventilator was an appropriate intervention. V7 (RT Director) also had told me that his white blood cell level was elevated (to 22,000). Based on that, I pre-ordered sputum culture and antibiotic due to suspected respiratory infection. Later, on 06/14/2024, I checked [R1]'s electronic medical chart and found out that he was transferred to the hospital. I could have sent [R1] to the hospital, but he was getting placed back on the ventilator, so I didn't think it was necessary. On 7/2/2024 at 4:06 PM V16 (Primary Care Physician) stated: Facility contacted me about [R1]'s condition at least a couple of times on 06/14/2024, but I don't remember nurses reporting that [R1] had elevated white blood cell level. The last time I remember I was called about [R1] was when the nurse, I don't remember their name, was trying to verify what ambulance service to use to transfer [R1] to the hospital. I think nurses should know what is appropriate for a resident at the time of change in condition, they are physically with the resident. I believe that if [R1] was provided higher level of care sooner, it is possible he would be alive today. Change in [R1]'s primary care physician dated 06/13/2024 at 9:38 AM reads in part, Team, please switch [R1) to (V16 - PCP). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Physician Notification of Laboratory/Radiology/Diagnostic Results dated 3/14/18 reads in part, Purpose: To assure physician ordered diagnostic test are performed, and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the resident's care. Guidelines: A licensed nurse is responsible for assuring the laboratory is notified of physician's orders for testing. STAT or Same Day orders will be called to the laboratory service by the nurse who transcribes the order. A nurse is responsible for monitoring the receipt of test results. Guidelines for Reporting Abnormal Results: All critical laboratory values - also called Alert or Panic values; x-ray or other diagnostic tests reveal suspected findings which may require immediate intervention. In the event a physician does not respond promptly to attempts to convey critical laboratory results, the alternate physician or Medical Director will be notified. Promptly may be defined based on the clinical condition of the resident and the judgement of the nurse in each individual situation. Unless other parameters are ordered by physician: WBC (White Blood Cells) > 12,000. The licensed nurse is responsible for documenting the notification of results in the clinical record.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interviews and record review, the facility failed to contact and notify a resident's primary care physician regarding the onset of a residents change of condition and failed to send a resident out via 911 when all interventions failed to correct an elevated heart rate. This failure resulted in a delay of [R1] being sent to the hospital for a higher level of care more than 15 hours after the onset of the high heart rate and subsequent death. This was identified as an immediate jeopardy. V17 (Director of Nursing) was notified in the administrator's absence of the immediate jeopardy on [DATE] and presented with an immediate jeopardy template. The facility presented an acceptable removal plan to department on [DATE] after items were revised. The Immediate Jeopardy began on [DATE] and was removed [DATE]. The non-compliance remains at a level- 2 since the failure has the potential to affect all residents at this level and the facility needs time to evaluate the effectiveness of the interventions. Findings include: [R1] is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Acute and Chronic Respiratory Failure with Hypoxia; Tracheostomy; Spastic Quadriplegic Cerebral Palsy; Seizures; Encounter for Attention to Gastrostomy; Myoneural Disorder; and Unspecified Intellectual Disabilities. [R1]'s life saving measures status as of [DATE] listed as: Full Code. [R1]'s care plan dated [DATE] reads in part, [R1] has a Tracheostomy s/p acute and chronic respiratory failure with hypoxia. Interventions: Monitor for signs/symptoms of respiratory distress (restlessness, agitation, confusion, increased heart rate (Tachycardia), air hunger, and/or bradycardia; Monitor level of consciousness, mental status, and lethargy PRN; Monitor respiratory rate, depth, and quality (work of breathing), Check and document every shift/as ordered. Resident has potential for alteration in respiratory functioning related to acute and chronic respiratory failure with hypoxia s/p tracheostomy. Interventions: Assess respiratory status, observe for shortness of breath, monitor lung sounds. Call physician for any changes in condition and as needed; Call physician for any changes in condition. [R1]'s progress note written by V12 (RN) dated [DATE] 6:45 AM reads in part, Nurse Name: (V12). Patient Name: ([R1]). Primary Chief Complaint: Medication request per patient. Vitals (not required): T: 98.3 (F). HR: 151 (bpm). BP Sys: 144 (mm/Hg) /Dia: 81 (mm/Hg). RR: 22 (rpm). SpO2: 96 (%). Summary: 32 yo M with hx of afib with HR up 100s. requesting metoprolol po now. ok to give metoprolol 50mg now. Orders: metoprolol 50mg po x1. Disposition: Stay at Facility. Statement of Medical Necessity: Yes. Consent for telemedicine/virtual visit obtained from patient/POA: Yes. [R1]'s progress note written by V18 (RN) dated [DATE] 11:23 AM reads in part, Received [R1] eyes wide open, HR of 148, not in any visible distress, BP:,d+[DATE], O2 @97%, RR 22. One time order for metoprolol 50mg per (V13) given. Post metoprolol HR at 120. Will continue to monitor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[R1]'s progress note written by V8 (RN) dated [DATE] 1:38 PM reads in part, Per (V7) with order from (V15) for chest x-ray. Order placed. [R1]'s progress note written by V17 (RT Director) dated [DATE] 3:23 PM reads in part, (At) 1515 ([R1]) abnormal VS in respiratory distress, HR 160 RR >35bpm (44) sat ,d+[DATE]% on TC 40%. Pt w/ small yellow thick secretions. AW patent, fio2 increased to 50%. WBC was 22.71 today, (V16 PCP) notified. (V15 Pulmonary Nurse Practitioner) notified, x-ray ordered. Pending results. ([R1]) will be placed on vent full support to prevent respiratory failure w/ settings AC 16 300 +5 40% per (V15). Will notify POA. [R1]'s progress note written by V15 (Pulmonary Nurse Practitioner) dated [DATE] 3:30 PM reads in part, Notified by (respiratory therapy) that ([R1]) for consult to be seen by our service on ,d+[DATE] 08:48am. Notified that ([R1]) on continuous (tracheostomy collar) at 40% and had a 7 TTS trach in place. Then was notified by (respiratory therapy) at (3:20 PM) that ([R1]) had developed increased work of breathing, tachypnea with counted RR 52, HR 150s and sats in low 90s. ([R1]) was given (heart rate lowering medication), cardiology consulted, and ([R1]) had WBC 22 (22,000). ([R1]) placed on mechanical ventilation. [R1]'s vital sign [DATE] timeline: 00:46 AM - HR 105 beats per minute, RR 20 breaths per minute - no interventions 3:20 AM - HR 151 beats per minute, BP ,d+[DATE], RR 20 breaths per minute - tele health medicine notified by V12 (RN), one time dose of heart rate lowering medication ordered and administered. 9:11 AM - HR 148 beats per minute, BP ,d+[DATE] - V8 (RN) confirms with V13 (Admitting NP) that scheduled dose of heart rate lowering medication can be given at 9:00 AM in addition to previous dose. 10:36 AM - RR 20 breaths per minute - no interventions 11:07 AM - HR 120 beats per minute - no interventions 11:23 AM - HR 148 beats per minute, RR 22 breaths per minute -- no interventions 1:34 PM - V15 (Pulmonary NP) notified, STAT chest x-ray ordered (completed but not resulted until [DATE] 9:50 AM) and antibiotic ordered (never given). 3:15 PM - HR 160 beats per minute, RR 44 breaths per minute - [R1] placed on the ventilator. 3:23 PM - WBC was 22.71- V16 (PCP) notified, no new orders. 3:29 PM - BP ,d+[DATE] - no interventions 3:34 PM - V14 (Cardiac NP) notified, orders given at 3:44 PM 3:40 PM - HR 153 beats per minute 3:44 PM - STAT EKG ordered (never completed), heart rate lowering medication ordered (given) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	3:51 PM - RR 31 breaths per minute - no interventions 4:45 PM - HR 130 beats per minute - no interventions 4:50 PM - RR 23 breaths per minute - no interventions 4:57 PM - HR 130 beats per minute, BP ,d+[DATE], RR 28 breaths per minute - no interventions 5:44 PM - HR 147 beats per minute - no interventions 5:59 PM - HR ,d+[DATE] beats per minute - V16 (PCP) notified; orders received to send [R1] to the hospital. 7:20 PM - HR 153 beats per minute, RR 33 breaths per minute, increased WOB - paramedics arrived. [R1]'s vital sign timeline shows delay in excess of 15 hours of recognizing and notifying primary care physician of resident's change in condition and need for higher level of care. No hospital transfer order found in [R1]'s electronic medical chart. The following orders were found in [R1]'s medical record. -[R1]'s Tracheostomy physician order dated [DATE], reads in part, High Humidity Tracheostomy Collar: FIO2 40% every day and night shift. -[R1]'s Ventilator physician order dated [DATE] at 3:30 PM reads in part, Mode: AC rate:16, Fio2: 40%, Peep: +5, Tidal Volume: 300. -[R1]'s medication physician order dated [DATE], reads in part, Metoprolol Tartrate Oral Tablet 50 MG, give 50 mg via G-Tube, give 1 tablet via G-Tube every 12 hours for HTN, Hold of SBP <110 or DBP <60. -[R1]'s medication physician order dated [DATE] at 9:31 AM, reads in part, Metoprolol Tartrate Oral Tablet 50 MG, Give 50 mg via G-Tube one time only for HTN for 1 Day. [R1]'s medication physician order dated [DATE] at 3:41 PM, reads in part, Cefepime HCl Solution Reconstituted 2 GM, use 2 grams intravenously every 12 hours for leukocytosis, suspected [NAME] for 7 days. -[R1]'s medication physician order dated [DATE] at 3:51 PM, reads in part, Diltiazem HCl Oral Tablet 30 MG (Diltiazem HCl), give 1 tablet by mouth every 6 hours for tachycardia, hold of SBP <100 and HR <70. Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083%, 3 ml inhale orally via nebulizer every 4 hours as need for shortness of breath and wheezing. -[R1]'s Respiratory Medication Administration Record dated [DATE] reads in part, Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3ml inhale orally via nebulizer every 4 hours as needed for Shortness of Breath/Wheezing; not documented, blank space. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[R1]'s Medication Administration Record dated [DATE] reads in part, Cefepime HCL Solution Reconstituted 2 GM; Use 2 gram intravenously every 12 hours for leukocytosis, suspected [NAME] for 7 days; documented as 6 = resident hospitalized , medication not given. Metoprolol Tartrate Oral Tablet 50 MG; Give 1 tablet via G-Tube every 12 hours for HTN Hold of SBP <110 or DBP <60; documented as given at 9:00 AM. Diltiazem HCL oral tablet 30 MG; Give 1 tablet by mouth every 6 hours for tachycardia Hold for SBP<100 and HR<70; documented as 6 = resident hospitalized ; medication not given. Metoprolol Tartrate Oral Tablet 50 MG; Give 50 mg via G-Tube one time only for HTN; documented as given at 9:46 AM. [R1]'s lab order dated [DATE] at 10:32 PM reads in part, Priority: Routine. CBC with Diff, Comprehensive Metabolic Panel, Lipid Panel w/reflex to direct LDL, Thyroid Stimuli Hormone, Hemoglobin A1C. Ordering physician: (V24 Admitting Physician). [R1]'s routine blood work ordered on [DATE] at 10:32 PM, collected [DATE] at 5:35 AM, results posted on [DATE] at 10:23 PM. WBC (White Blood Cells) 22.71 H (reference range 3XXX,d+[DATE].8). [R1]'s x-ray order dated [DATE] at 1:34 PM reads in part, Priority: STAT. Chest, 2 views. Ordering physician: (V15 Pulmonary Nurse Practitioner). [R1]'s STAT chest x-ray radiology report dated [DATE] reads in part, There is some patchy density at the right base suspicious for infiltrate. The left lung is overall clear. [R1]'s EKG order dated [DATE] at 3:44 PM reads in part, Priority: STAT. EKG. Routine, w/at least 12 leads, w/interpretation, and report. Ordering physician: (V16 Primary Care Physician). [R1]'s STAT EKG radiology report dated [DATE] reads in part, Canceled Study. [R1]'s vital sign timeline shows delay in excess of 15 hours of recognizing and notifying primary care physician of resident's change in condition and need for higher level of care. (continued on next page)

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	145630	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care North Branch	6840 West Touhy Avenue Niles, IL 60714

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The local fire department ambulance's patient field care report contained the following information for services given to [R1] on [DATE]. [R1]'s ambulance run sheet dated [DATE] 7:26 PM reads, (Paramedic) dispatched to the above address for an unresponsive person. UOA (upon arrival), (Paramedic) found the ([R1]) lying supine in bed, staring to the right (V19) at his side, on a vent. ([R1]) is alert to his norm per RN (V10), but (V19) said that ([R1]) usually blinks and she hasn't seen him blink during the time she was there with him. The RN (V10) said that ([R1]) was tachycardic and gave him (heart rate lowering medication). (Paramedic) asked how much and when, the RN (V10) scratched his head and then walked away. ([R1]) is [AGE] year but has a body size of a [AGE] year old. ([R1]) is on O2 via trach, has a (urinary catheter) and G-tube. The RN (V10) handed (paramedic) a piece of paper with '(heart rate lowering medication)' written on it. (Paramedic) asked the RN (V10) what time he gave the medication. The RN (V10) said that he couldn't give more due to his B/P (blood pressure). Afterwards, (paramedic) asked what was the ([R1]'s) initial HR (heart rate) and B/P (blood pressure). The RN (V10) had a PCT (patient care technician) empty (urinary catheter) bag and then left the room. ([R1]'s) arms and legs were cool to the touch, but the ([R1]'s) core and head were warm to the touch. ([R1]) was moved to the cot via sheet. (Paramedic) bagged the ([R1]) via trach with a BVM (bag-valve-mask). No resistance felt when bagging. ([R1]'s) pulse and ETCO2 (end tidal [NAME] dioxide) were dropping. (Paramedic) noticed the ([R1]'s) HR (heart rate) dropped from 60's to 38 (beats per minute). (Paramedic) checked a manual HR (heart rate) and unable to feel a carotid or radial (pulse). At that time, (paramedic) noticed the rhythm was asystole. CPR (cardio-pulmonary resuscitation) initiated. (Paramedic) called (destination emergency department) back with update of a cardiac arrest. [R1]'s Death Certificate dated [DATE] reads in part, Cause of Death: A. Bilateral Pulmonary Embolism Non-Traumatic; B. Bilateral Hemorrhagic Pulmonary Consolidation; C. Thrombosis Left Iliac Vein. On [DATE] at 12:39 PM V7 (Respiratory Therapy Director) stated: [R1] was admitted to the facility on [DATE]. [R1]'s initial oxygenation orders were for tracheostomy collar 40% fio2 (5 liters per minute, fraction of inspired oxygen). [R1] was stable on those settings on [DATE] and [DATE]. Around 9:00 AM on [DATE] I was notified by V9 (Respiratory Therapist) that [R1] developed tachycardia (elevated heart rate) but had clear airway and appropriate oxygen saturation level. [R1]'s respiratory rate was into mid 20 breaths per minute, but it was not critical. I assessed [R1] at that time, and, following my assessment, I notified nurse on duty (V8 - Registered Nurse) and V15 (Pulmonary Nurse Practitioner). We are required to notify nurse on duty and pulmonary physician if we notice any resident change in condition. I was concerned with [R1]'s tachycardia. There were no new orders from respiratory side at that time, just to closely monitor. Around 3.15 PM, [R1] was in distress. [R1]'s heart rate was in 150's bpm (beats per minute), respiratory rate was over 35 breaths per minute, rapid and shallow, and oxygen saturation was ,d+[DATE]% on tracheostomy collar. I immediately notified V15 (Pulmonary NP) and I received orders to place [R1] on ventilator to prevent respiratory failure. Right when, I placed [R1] on the ventilator. I notified V19 ([R1]'s family member) via phone, explained reasons behind putting [R1] on ventilator, and I also assured her that I will make sure [R1] has a private room. Based on V19's input, [R1] was sensitive to surrounding stimuli, including roommate's noise and such, so ` him in the private room. If our interventions would not work, we would call 911 at that time; however, respiratory therapy interventions were effective, [R1]'s oxygenation improved, respiratory rate decreased, and heart rate remained elevated, but it would not be an indication to be concerned from respiratory side; therefore, I didn't feel that it was appropriate to call 911 at that time. We also received stat orders for chest x-ray. Before I left, I gave [R1] PRN (as needed) breathing treatment, and [R1] appeared stable. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 1:22 PM V8 (Registered Nurse) stated: I worked [DATE] from 7:00 AM to 3:00 PM. I was assigned to care for [R1] that day. When I arrived at work, around 6.30 AM, I received a report from overnight nurse (V12 - Registered Nurse), that [R1]'s heart rate was in 150's bpm (beats per minute) and he was given medication to lower his heart rate around 4:50 AM. During my morning assessment, [R1]'s heart rate was about 148 bpm, but he didn't appear in any distress, [R1]'s respiratory rate was ,d+[DATE] breaths per minute and his blood pressure was also within normal range. Normal heart rate range is ,d+[DATE] bpm and respiratory rate ,d+[DATE] breaths per minute but [R1] didn't seem to be in distress. V13 (Admitting Nurse Practitioner) was on-site, so I told her about events from last night and this morning regarding [R1], and V13 (Admitting NP) said to give him another dose of medication to lower his heart rate, which was scheduled at 9:00 AM regardless. I went back around 10:00 AM to check on [R1], his heart rate was at 120 bpm at the time, V13 (Admitting NP) recommended further monitoring but didn't place additional orders. [R1]'s heart rate remained in the 120 (bpm) range. I checked [R1]'s vital signs twice more before the end of my shift (at 3:00 PM) and there was nothing concerning. If a resident has a change of condition, we are supposed to notify primary doctor or nurse practitioner and assess the resident. I don't believe there was nothing else I could have or should have done, because only [R1]'s heart rate remained in 120s (bpm), even though his heart rate was outside of normal range, I don't think there was anything else that should have been done. Heart rate could be elevated due to anxiety, infection, heat, respiratory issue, it could be several things. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 2:21 PM V9 (Respiratory Therapist) stated: I worked on [DATE] from 7:00 AM to 7:00 PM. I don't remember getting concerning report about [R1] from off going respiratory therapist. During my initial rounds, around 7.45a-8.15a, I noticed [R1] was tachycardic, his heart rate was over 150 (bpm). I informed V8 (RN - nurse on duty). From respiratory standpoint, [R1]'s oxygen saturation and respiratory rate were within normal range. V8 said that she would notify [R1]'s primary care doctor. After that, between 10a-12p, I did routine check on [R1]. [R1] was stable respiratory-wise, oxygen saturation and respiratory rate were within normal range, his heart rate was improved but remained over 120 bpm which is not withing normal range. I followed up with V8 and she confirmed that she was aware. I did next routine check between 2:00 PM - 2:30 PM. I have noticed that [R1]'s respiratory rate was over 30 breaths per minute, in addition, I noticed increased labor of breathing and use of accessory muscle. [R1]'s oxygen saturation was in high 80s (%) which is below normal range. [R1]'s was breathing was harder and faster than it should be, his respiratory status was jeopardized and required intervention. Before notifying anyone, I initiated interventions such as [R1]'s breath sounds and airway patency assessment, I suctioned [R1]'s tracheostomy, and I placed continuous pulse oximeter for monitoring. I did not notice any improvement in [R1]'s condition. At that point, I notified V7 (RT Director) to get a second opinion. I told him what intervention I had done. V7 notified V15 (Pulmonary NP) and we were given orders to place [R1] on a ventilator. After connecting [R1] to a ventilator, his oxygen saturation and respiratory rate improved to a normal range after; however, [R1]'s heart rate remained elevated between ,d+[DATE] bpm. We continuously monitored [R1] pulse oximetry and ventilator alarms. [R1]'s ventilator alarm was signaling high PEEP (positive end-expiratory pressure), which means that there might be some sort of obstruction in his airway. Peep alarm can be triggered by anxiety as well. Generally speaking, [R1] was fighting the ventilator. I notified V10 (LPN - afternoon nurse on duty). V10 (LPN) checked on [R1] and said he will give him some medication. I continued monitoring until around 4:00 PM - 5:00 PM, but I exhausted all respiratory interventions, yet [R1] remained triggering high PEEP alarm. At that point, V10 (LPN) contacted V16 ([R1]'s primary care physician) and received orders to send [R1] to the hospital, but it wasn't via 911. V10 (LPN) requested transport ambulance. V19 ([R1]'s family member) came in around 6.30 PM, after being notified of [R1]'s change of condition and placing him on the ventilator. V19 requested V10 to call 911. Paramedics arrived around 7.20 PM. Before that, around 7:00 PM, I completed a hand of report to the night shift respiratory therapist, I pointed out the need for [R1]'s continuous monitoring, elevated heart rate, and alarming vent, and I went home. On [DATE] at 3:15 PM V10 (Licensed Practical Nurse) stated: I started my shift around 3:00 PM on [DATE]. I noticed respiratory therapist placing [R1] on the ventilator. V8 (RN) said that [R1]'s heart rate was high during her shift, but they were able to control it. I assessed [R1] upon the beginning of my shift, and I noticed that his heart rate was elevated to about 145 -150 bpm. I notified the V17 (Director of Nursing). V17 (DON) V14 (Cardiac Nurse Practitioner), V14 (Cardiac NP) gave an order for medication to lower [R1]'s heart rate. I gave it to [R1], his heart rate didn't really improve, but his blood pressure decreased, I don't remember the exact numbers and I didn't document it, so I called V16 (Primary Care Physician). V16 (PCP) questioned me why wasn't [R1] sent out to the hospital throughout the day, and then, after further medical record review, V16 proceeded to give me an order to send [R1] to the hospital via transport ambulance. I questioned V16's decision and suggested that we should call 911; however, V16 said that if V14 (Cardiac NP) and V15 (Pulmonary NP) assessed [R1] earlier and didn't feel there was a critical need to send [R1] via 911, I should schedule transport ambulance to send him to the hospital. I scheduled transport ambulance for 9:00 PM. When V19 ([R1]'s family member) arrived in the facility, she looked at [R1] and insisted on calling 911. I then called 911. Paramedics arrived around 7:20 PM, they assessed [R1]'s vital signs, placed him on their stretcher, and transported him out of the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 9:45 AM V13 (Admitting Nurse Practitioner) stated: I did not physically see [R1] on [DATE]; however, I admitted him on [DATE], and I was most familiar with [R1] when nurses called to notify about [R1]'s elevated heart rate. I'm in the facility on daily basis and it is easiest to reach me out of most medical staff. I confirmed that it is ok to give [R1] scheduled dose of medication to lower [R1]'s heart rate at 9:00 AM after receiving previous dose of the same medication earlier that morning. I was also waiting for routine blood test to come back that I ordered upon [R1]'s admission (on [DATE]). I also asked if [R1] is being followed by a cardiologist. Considering [R1] was treated for pneumonia prior to coming to the facility and being new to tracheotomy, I wasn't overly concerned with his tachycardia. I would become more concerned if [R1] developed additional symptoms, the rule of thumb is that, at least three elements of vital signs are abnormal, it might be an infection or sepsis, and it is appropriate then to send a resident out to the hospital. Knowing that his white blood cells level was elevated (to 22,000) in additional to tachycardia, I would definitely send him out to the hospital; however, I was gone (around 11:30 AM) by the time those blood work results came back. On [DATE] at 10:12 AM V14 (Cardiac Nurse Practitioner) stated: I was consulted to see [R1]; however, I did not see him that day ([DATE]). In the afternoon of [DATE], I was told that [R1] had a fast heart rate and was going to be placed back on the ventilator. Nurses asked me if I could see [R1] next time I'll be in the facility (Tuesday [DATE]). Fast heart rate can be associated with respiratory distress or failure, but I did not know his medical history. I always investigate resident's chart before I give orders; therefore, based on [R1]'s chart review, EKG (electrocardiogram) and heart rate lowering medication were two most appropriate orders. I was not aware that [R1]'s white blood cells level was elevated at that time. I don't know if my orders were carried out by the nurses. I did not receive any results of EKG. I don't know what happened after that. Typically, I don't send residents to the hospital, but if I feel the need, I will let the nurse know. For [R1], I didn't feel the need to send him out to the hospital. When I was told he was going back on the ventilator, it seemed like an appropriate intervention. I treat residents' fast heart rate fairly appropriate who reside in long term care facilities, I get often consulted for that. I did not know [R1] expired later that day, this is the first time I hear about it. On [DATE] at 10:59 AM V15 (Pulmonary Nurse Practitioner) stated: On [DATE] at 8:48 AM, I was notified that there was a new resident that I was consulted for. Even though, [R1] was admitted on the evening of [DATE]. I've never seen [R1] face to face, it is pretty typical though. V7 (RT Director) told me that [R1] was admitted with tracheostomy collar, verified orders for the tracheostomy with me, and that was it. Nothing unusual at that point. Later that day, at 3:20 PM, I was notified that [R1] had increased respiratory rate, to over 40 breaths per minute. V7 (RT Director) actually said that [R1]'s respiratory rate was 52 breaths per minute at that time, heart rate was in 150's bpm (beats per minute), his oxygen saturation level in the low 90%, and he was breathing shallow, all of which would tell me, [R1] was in acute respiratory distress. V7 (RT Director) asked for an order to put [R1] on the ventilator and for ventilator settings. Given [R1]'s condition, placing him on the ventilator was an appropriate intervention. V7 (RT Director) also had told me that his white blood cell level was elevated (to 22,000). Based on that, I pre-ordered sputum culture and antibiotic due to suspected respiratory infection. Later on [DATE], I checked [R1]'s electronic medical chart, and found out that he was transferred to the hospital. I could have sent [R1] to the hospital, but he was getting placed back on the ventilator, so I didn't think it was necessary. We usually try to stabilize residents in the facility; I feel that the facility is able to handle respiratory events, have qualified staff and appropriate equipment to do so. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 11:23 AM V16 (Primary Care Physician) stated: If you see someone in distress, you should call 911, not point fingers at other people. The problem is that there are too many agency nurses in the facility. Agency nurses don't care as much. Nurses should call 911 regardless of doctor's and family's opinion if a resident needs critical care. I rely on facility's nursing staff and what I'm told, they are my eyes and ears. Sometimes transporting via regular ambulance makes sense, but [R1]'s heart rate and respiratory rate showed that 911 should have been called. I never insisted on ordering transport ambulance for [R1]. At the very least, staff should have called 911 after second dose of heart rate lowering medication administered at 9:00 AM. It shows that didn't consistently bring [R1]'s heart rate down, so 911 should have been called at the latest around 11:00 AM - 12:00 PM. On [DATE] at 11:45 AM V12 (Registered Nurse) stated: On [DATE] around 3:00 AM, I was notified by respiratory therapist, that [R1]'s heart rate was in 150's (bpm), so, based on that, I reached out to tele health service, and I received an order for heart rate lowering medication. I gave it to [R1] as soon as I receive an order, not sure the exact time. I rechecked his heart rate 30 minutes after I gave medication, and it was around 120s (bpm). After that, around 6:00 AM, I gave [R1] his scheduled medications, and I rechecked his heart rate again, it was 98 (bpm) at that time. Considering [R1]'s heart rate was within normal range, and I endorsed it to the morning shift nurse (V8) and went home. On [DATE] at 11:59 AM V17 (Director of Nursing) stated: I was here (in the facility) on [DATE]. When I looked at [R1] around 3:30 PM, [R1] was already placed on the ventilator. I assessed him, he didn't have any abnormal breath sounds or heart sounds, did not appear to be in respiratory distress; however, [R1]'s heart rate was in high 130s to low 140s (bpm). I spoke to V14 (Cardiac NP), she prescribed heart rate lowering medication and STAT EKG. [R1] was sent out to the hospital before EKG was completed. V10 (LPN) updated V16 (PCP) about [R1]'s condition, and that's when V16 ordered [R1] to go to the hospital. I'm not sure about the exact order of events after that because I left for the day around 4:30 PM. Emergency is considered when there is a sudden change in resident's condition or if any type of injury occurs that can't be managed in the facility. If a resident with tracheostomy can benefit from the ventilator, they will be placed on it. [R1]'s elevated heart rate and white blood cell level, and later respiratory distress, didn't prompt us to call 911 because [R1] was managed by pulmonary, cardiac, and primary care providers. If there is an emergency beyond the capacity of the facility, 911 should be called. [R1]'s condition was managed appropriately until the time 911 was called, so around 7:20PM. I'm not sure if V10 (LPN) called 911 in addition V19 or it was V19 who called, considering V10 already scheduled transport ambulance at that time. I'm not sure if V10 would have called 911 without V19's persistence. Nurses can call 911 against physician's advice, it is within their scope of practice. Especially being physician's eyes and ears, nurses have better picture of the situation. I believe all staff interventions were appropriate for [R1] on [DATE]. I feel that nurses were pro-active enough in providing timely care. We did not discuss [R1]'s incident in QAPI meeting nor had any in-service for staff. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 4:10 PM In follow up interview, V17 (DON) stated: I believe V15 (Pulmonary NP) was on [R1]'s case and [R1]'s primary driver was his respiratory status; therefore, V16 was not notified until 5:59 PM. At the time of [R1]'s distress, around 3:30 PM, when his heart rate was in 160's (bpm), respiratory rate in 40s (breaths per minute), and white blood cell level results were known, V15 (Pulmonary NP) already placed an order for a ventilator. V16 (PCP) was not notified at 5:59 PM when all respiratory and cardiac interventions were exhausted. In regard to ordered laboratory and diagnostic tests, [R1]'s EKG was not completed on [DATE] because he was transported to the hospital. [R1]'s chest x-ray didn't result until the morning of [DATE], and blood work started posting in the portal in the early afternoon of [DATE]. CBC (Complete Blood Count) is prioritized, so it was most likely posted as a partial result and that's how nurses were aware of [R1]'s elevated white blood cell level before 10:23 PM when the rest of [R1]'s blood work results were available. [R1] was a hard stick, his blood sample was not collected until the morning of [DATE], even though the order was placed on [DATE]. Our laboratory doesn't notify us of any abnormal lab results, so it is up to the nurses to follow up on that. On [DATE] at 1:05 PM In follow up interview, V8 (Registered Nurse) stated: I didn't notify V16 (PCP) of [R1]'s change of condition on [DATE] because I wasn't aware of change of primary physician for him. [R1] was assigned to another primary physician when he was initially admitted on [DATE] and then it changed. Besides, V13 (Admitting NP) was on site and was aware of [R1]'s elevated heart rate from previous night, so I just asked her. Later that day ([DATE]), I called around 11:00 AM and spoke to V16. I told him about [R1]'s elevated heart rate, confirmed that he wasn't in any distress, and verified that [R1] had his blood drawn in the morning and results are still pending. V16 told me to monitor [R1] and notify him of blood work results. I checked for [R1]'s blood work results around 1:15 PM, and they were not posted at that time. I didn't talk to V16 again before the end of my shift. Another test for [R1] that was ordered during my shift, was STAT chest x-ray, but I don't remember it being done. In case resident's change of condition, nurse should notify their primary physician. Resident's profile lists their primary care physician, I didn't recheck [R1]'s assigned primary care physician on the morning of [DATE], I assumed it was the same as upon admission. On [DATE] at 1:46 PM V18 (Administrator) stated: I was notified of [R1]'s hospital admission and later succumbing to his change in condition in the evening of [DATE]. I was out of town at that time. I asked if V17 (DON) and V7 (RT Director) were looking into it, meaning if they are looking at reasons why [R1] was sent out and what was the reason for his change in condition. I didn't follow up after that. I didn't notify medical director. I'm not aware of any additional education provided to staff following the incident. On [DATE] at 2:52 PM In follow up interview, V10 (LPN) stated: If resident displays change in condition, nurses should notify V17 (DON) and resident's primary care physician. Right upon the beginning of my shift (around 3:00 PM), I notified V17 (DON) of [R1]'s elevated heart rate. I don't know why I didn't notify V16 (PCP) along with V17 (DON), don't have answer to that. I notified V16 (PCP) one time during my shift. I don't remember exactly the time, but I documented at 5:59 PM. It had to be before 5:00 PM though because we cannot notify V16 (PCP) after 5:00 PM, we need to [TRUNCATED]