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	08/05/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516 Based on observation, interview and record review, the facility failed to follow their fall prevention program by failing to ensure the safe transfer/handling of a resident during care, failed to follow their plan of care to prevent further falls, and failed to keep the resident's immediate surroundings free of accidental hazards. This failure affects 1 (R1) of 4 residents reviewed for falls and resulted in R1 being emergently transferred to the hospital and admitted with acute pain and right knee fracture. Findings include: R1 is a [AGE] year old with diagnoses including but not limited to fracture of medial condyle of right tibia, fracture of seventh cervical vertebra, hypertensive heart disease, congestive heart failure, chronic obstructive pulmonary disease, spinal stenosis and repeat falls. Facility records showed post-fall assessments indicating R1's numerous falls on 7/9/23, 8/14/23, 10/21/23, 12/21/23, 3/4/24, 6/28/24, and with the most recent 7/6/24 which led to the emergency room transfer on 7/8/24 where R1 was diagnosed and treated for a knee fracture. On 8/3/24 at approximately 10:10 AM, surveyor entered R1's room which appeared dark and with no lighting turned on. R1 was lying awake in the first bed and a call light cord appeared above R1's bed away from her reach. There was one fall mat on the right side of the bed, however on the left side of the bed was a folded up fall mat was away from the bed itself. A bedside table was placed atop the right fall mat and had no personal items, water, or phone and did not appear to have any purpose. R1 was awake and able to answer surveyor's line of questioning. R1 knew her name, where she was living, and indicated it was 2024 and added, Why do people keep asking me? Surveyor asked what had happened to her right leg as she was wearing a leg brace. R1 said she had fallen after an altercation with some staff member. Surveyor asked what kind of altercation and if she knew who the staff person was, R1 said it was just a disagreement and the staff person was just careless and did not pay attention when she was transferring onto the wheelchair. Surveyor asked if this staff person said anything inappropriate to her, R1 stated, No, but I know she's Mexican with blonde hair. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Surveyor asked R1 how she was feeling today and if the nurse had seen her this morning. R1 said she was feeling lousy and said she saw the nurse earlier when she got her medications. R1 also said she was not sure if her pain on her knee started after a chair transfer or if it happened while she was showering. R1 indicated when she was hospitalized , she forgot the timeline of events and everything became a blur when she was in the hospital. Surveyor asked about the shower and who assisted her to shower, R1 indicated it was a male staff person. Both occurrences were later affirmed by V3 (assistant director of nursing). R1's care plan dated 6/5/23 reads in part, (R1) at risk for falls. Gait/balance problems, pain secondary to cervical spinal stenosis with myelopathy and lumbar spinal stenosis status post cervical compression and fusion followed by lumbar compression and fusion, chronic left hemiplegia. Goal: R1 will not sustain serious injury through the review date. Interventions: Provide visual prompts call don't' fall in resident room. Apply bilateral floor mats when resident is in bed. Bed in lowest position. Falling leaf sign in place. Keep items, water, etc. in reach. Remind resident to call for assistance when ambulating. On 8/2/24 at 11:15 AM, V2 stated, She (R1) is confused and has psych affective disorder and a history of fabricating stories, history of verbal aggression towards staff. She fabricates like answering call lights. She is interviewable and she is here for fracture before, and she had neck fracture from upon admission She said she was going to go to the bathroom but then she was attempting to try to get out of bed and kicked the stand for the bedside table and bumped with her knee. She did not use the call light and she went back to bed. Surveyor asked if the resident is confused how V2 expected for the resident to use a call light to get assistance. V2 had no response. Surveyor asked if it was possible a bump into a side table could sustain an injury such as a knee fracture. V2 indicated that was what was reported to him. On 8/2/24 at approximately 12:30 PM, V3 (ADON) called V5 (night nurse) to speak to the surveyor. V3 remained in the room to witness the conversation. V5 stated, R1 was sleeping throughout the night without complaint and then early in the morning she was asking for ice pack while I was passing my morning medications. I assessed her knee and there was no swelling in sight, and she asked for stronger pain medications. I gave her the ice pack and put it on her knee. I asked do you need pain medication. That was all she told me and there was no swelling or any injury I saw. I did not even know she fell , and she did not get up at all during my shift because normally everyone is sleeping so she did not fall during my shift. I assessed her knee because I am feeling something on her knee, but I did not write any of this down, but I should have. That is a mistake on my part. V5 stated, She (R1) said my knee is pain and sometimes she has an attitude, but she did not say to look at her knee. When she asked for the ice pack, she said she was feeling pain on her knee, so I asked her what's really going on with her knee. She just said to give me ice pack for swelling. She did not allow me to look at her knee. She just said she has pain. Surveyor asked if V5 did any assessment or palpating (examine by touch) of her knee. V5 said, Yes I palpated her knee but like I said I didn't write this down. Surveyor reminded V5 earlier she indicated the resident didn't allow her to touch her knee but now she's claiming she palpated her knee. V5 said, I did assess her (R1) knee and all she tell (sic) me about the knee. She told me all I need is an ice pack, that is the reason. Surveyor asked if she knew how R1 got injured. V5 stated, I don't know what happened with the knee. She did not explain to me what happened, but I should have asked her, so I did not get part of the story. I didn't know what happened to her that night. I don't know anything. I was the only nurse night and there is no manager on duty, and I did not endorse this incident to the next shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	After this interview, surveyor asked V3 (ADON) whether V5 night shift nurse assessed R1's knee or just gave her the ice pack without looking at the knee, V3 said, I don't think she looked at the knee at all. Surveyor asked when the facility discovered R1's knee injury, V3 stated, It was the following shift on Monday 7/8/24 after V5 gave the ice pack to the resident. The nurse V8 (RN) assessed R1's knee because she complained of pain and didn't want to get up for therapy so that was when V8 assessed the resident and called the doctor for a stat x-ray. We tried to trace back how she may have gotten the injury. She was showered the day before on 7/7/24 by V7 (CNA) but there was no report of any fall. Then the DON (V2) investigated it and determined she may have hit her knee on the bedside table. Surveyor asked if the facility determined whether the resident sustained the fracture during transfer, during showering, or hitting of the bedside table. V3 indicated, their investigation was inconclusive. Review of R1's MDS (minimum data set) dated 4/29/24 prior to the incident showed R1 requiring substantial assistance with showering, and tub/shower transfers however was only provided this task by only one staff member V7. V7 (CNA) could not be reached for interviews after several attempts to call from surveyor and from administration. On 8/2/24 at approximately 1:00 PM, surveyor returned to R1's room. Outside the room were 3 names of residents residing in the room, one of which was R1 who was in bed 1. There were no indications or symbols denoting R1 was on any falling leaf program to designate the resident as being at risk for falls. As surveyor entered, the room remained darkened and with the resident in the same position and with one floor mat on the right and a folded up fall mat to the left and away from the bed. The call light remained above R1's head and away from her reach and there were no signs for the resident to prompt resident to call don't fall as indicated in the resident's plan of care. V3 (assistant director of nursing) was shown what surveyor had observed. V3 indicated the folded up mat should have been unfolded and extended across the floor to protect the resident from falling. V3 indicated she did not know where the signs to prompt R1 to call before she fell and acknowledged the call light was not within reach of the resident. V3 proceeded to move the bedside table atop the right floor mat which could have been an accidental hazard and had no purpose beside the resident as it had no other items on it the resident could have used. Surveyor asked V3 if she could ask R1 about her knee and to see if we could examine the injury. With R1's permission, V3 removed the right leg brace and showed the surveyor the fractured knee. V3 said there was some swelling remaining and slight bruising in the center of the knee area. Surveyor and V3 asked the resident if she was in any pain. R1 stated, I'm in pain when I'm moved. R1 went on to describe how she fell and said it may have occurred when V9 (CNA) transferred her to her wheelchair or when she was showered by V7 (CNA) but could not recall anymore. Surveyor asked when she started feeling the pain on her knee. R1 stated it was when she asked the night shift nurse for ice to put on her knee when she noticed there may have been a problem with her knee. Surveyor asked if V5 (night nurse) gave her the ice and if the nurse looked at her knee to assess her pain. R1 stated, No, she never looked at my knee. She just gave me the ice and left. Surveyor asked if V5 inquired why R1 needed the ice pack. R1 stated, No. She seemed very busy, and I saw her only once at the end of her shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	V6 (CNA) statement taken by V2 (DON) pertaining to R1's fall incident of 7/7/24 reads in part, Around 4:30 AM when I was changing R1 diaper she asked for an ice pack for her knees. She said she bumped her leg on the side table when she was going to get up to go to the bathroom. I gave her the ice pack from nurse (V5) and nurse looked at her right knee, but it wasn't swollen or anything. She (R1) said she just went on her briefs because she no longer wanted to get up after that just happened. She went back to sleep, and she did not wake up again for the rest of my shift. V6 (CNA) could not be reached for interviews after several attempts to call from surveyor and from administration. On 8/2/24 at approximately 2:15 PM, V8 stated to surveyor, The resident (R1) told me she doesn't want to get up because she was supposed to be getting physical therapy and so didn't want to get up and said her legs hurt. I checked and noticed her right knee was swelling. I gave her Tramadol (for pain) and she requested an ice pack. This was probably Monday around 9:30 in the morning and I called the NP right away to get an order for X-ray and the results were positive for a fracture, so we sent her out to the emergency room , and she was admitted for a knee fracture but no surgery just immobilizer. Hospital records authored by V10 (hospitalist doctor) reads in part, R1 is a [AGE] year old who presented to the emergency room with chief complaint of fall. Patient is alert and oriented to person, place, and year. Patient says she had a quarrel with a staff member, and they moved the wheelchair causing patient to fall at nursing home. Patient is not sure which day the fall happened. Per ER note, patient fell in the shower. She complaint of neck pain which says is worse, also complaints of low back pain and abdominal pain. CT knee without contrast result date 7/8/24 clinical indication: Right knee fracture. There is a moderate lipohemarthrosis decompressing into a 2 cm Baker's cyst. There is mildly scattered superficial subcutaneous edema. Impression: 1. Acute intra-articular medial tibial plateau fracture. Fall prevention policy and procedures dated 11/21/2017 reads in part, The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Fall/safety interventions may include: The resident's personal possessions will be maintained within reach when possible. These items include tissues, water, drinking glass and phone. Assistive devices such as walkers and canes will be placed within reach of those residents who have physician's orders to ambulate independently. The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards. Lighting will be appropriate for the time of day and in accordance with the resident's desire and the plan of care. Call lights are answered promptly. Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet. Transfer conveyances shall be used to transfer residents in accordance with the plan of care.