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	04/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on observation, interview, and record review the facility failed to feed a resident in a dignified manner, for one of 12 residents (R44) reviewed for dining task and failed to provide feeding assistance to cognitively impaired resident with history of weight loss for one of three residents (R29) reviewed for feeding assistance in the sample of 27. Findings include: 1. R44's face sheet documents R44 is a [AGE] year-old admitted to the facility on 5.16.2023 with diagnoses including but not limited to: Hypertensive heart and chronic kidney disease with heart failure and with stage 5 kidney disease, Dependence on renal dialysis, Type 2 diabetes mellitus, and unspecified atrioventricular block. R44's MDS (Minimum Data Set of 4.8.2024) documents R44 is cognitively intact. On 4.20.2024 at 12:09 PM, V7 (Certified Nursing Assistant) was observed standing at R44's bedside while feeding resident. On 4.20.2024 at 12:16 PM, V7 said, I should be sitting when I feed residents. Feeding and Assisting Residents to Eat policy (undated) documents in part, Nursing personnel assisting should be positioned/seated at eye level with the resident to provide a relaxed and comfortable environment, and to avoid a standing over image. 35432 2. On 04/21/2024, at 12:03 PM, R29 was having lunch. R29 was triggered for weight loss during the annual survey. R29 was given pork loin, stuffing, green beans, and apples to eat. R29 was able to feed herself some apples and told the surveyor she was alright. At 12:05 PM, R29 drank some of her juice with a straw. She then used her spoon to give herself some coffee. At 12:10 PM, R29 told an aide that she was done with her meal. R29 did not consume any pork, stuffing or vegetables. At 12:11 PM, the aide took R29's lunch tray away. No staff offered R29 anything else to eat, assist R29 with lunch or encourage R29 to eat her lunch. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/2024, at 10:47 AM, V5 (Dietary Consultant) stated, R29 had a history of continuous weight loss. I make the dietary recommendations and the nursing staff should be carrying them out. I can encourage people to follow the recommendations, but I cannot ensure they get carried out. On 04/22/2024, at 11:10 AM, V24 (Certified Nursing Assistant) stated, Staff should observe and sit with her. She is losing weight and staff need to keep an eye on her. She will take a couple of spoon fills and then say she will say take it away or that she does what it. Someone should be with her. Aides can look up to see on her electronic chart to see what kind of assistance she requires.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on observation, interview, and record review, the facility failed to ensure residents who were self-administering medications had a self-medication administration evaluation and a care plan (R55, R105) and failed to have a physician's order for self- administration of medications (R105) for three of three residents reviewed for self-administration of medications in the sample of 27. Findings include: 1. On 4.20.2024 at 12:28 PM, two Fluticasone Propionate Nasal sprays were observed at R55's bedside. V55 said he self-administers the nasal spray. R55's face sheet documents R55 is a [AGE] year-old admitted the facility on 3.31.2024 with diagnoses including but not limited to: Hypertensive heart disease with heart failure, Acute and chronic respiratory failure with hypercapnia, Dependence on supplemental oxygen, Unspecified asthma, and Morbid (severe) obesity due to excess calories. R55's MDS (Minimum Data Set of 4.7.2024) documents R55 is cognitively intact. R55's Self-medication administration evaluation was completed on 4.21.2024. R55's care plan (will self-administer nasal spray) was initiated on 4.1.2024. 2. On 4.20.2024 at 1:32 PM, with V2 (Director of Nursing), three bottles of supplements (Ashwagandha Capsules, Lysine Tablets, Turmeric Capsules) were observed on R105's over the bed table. R105's face sheet documents R105 is a [AGE] year-old admitted to the facility on 11.17.2023 with diagnoses including but not limited to: Acute and chronic respiratory failure with hypoxia, Acute and chronic respiratory failure with hypercapnia, Chronic obstructive pulmonary disease, Morbid (severe) obesity with alveolar hypoventilation, Type 2 diabetes mellitus with diabetic neuropathy, and chronic kidney disease, stage 1. R105's MDS (Minimum Data Set of 3.1.2024) documents R105 is moderately impaired. R105's Self-medication administration evaluation was completed on 4.20.2024. R105's care plan (will self-administer supplements, nasal spray) was initiated on 11.18.2023. All interventions were initiated/revised on 4.21.2024. R105's order summary report documents the following orders all with order dates of 4.20.2024: Ashwagandha Oral Capsules Give 1 capsule by mouth one time a day. Supplement unsupervised self-administration, Lysine Oral Tablet 1000 mg Give 1 tablet by mouth one time a day. Supplement unsupervised self-administration, and Turmeric Oral Capsule Capsules Give 1 capsule by mouth one time a day. Supplement unsupervised self-administration. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.23.2024 at 8:50 AM, V2 (Director of Nursing) said, an assessment (self-medication administration) and physician's order must be obtained, and a care plan should be completed before a resident may self-administer medication. V2 said the resident should understand the dosage, what the medication is for, and the risks and benefits of the medication. Bedside Medication Storage Policy (Effective 10.25.2014) documents: Bedside medication storage is permitted or resident who wish to self-administer medications, upon the written order off the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team.

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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** 15301 Based on observation, interview, and record review, the facility failed to ensure that low air loss mattresses were set at appropriate weight settings for five of five residents (R70, R80, R105, R124, R129) reviewed for low air loss mattresses in the sample of 27. Findings include: 1. On 4.20.2024 1:05 PM, R124 was observed resting in bed on a low air low mattress; weight was set for 230 pounds. V2 (Director of Nursing-DON) said, R124 doesn't look like he weighs 230 pounds. R124's face sheet documents a [AGE] year-old admitted to the facility on 12.4.2023 with diagnoses including but not limited to Sepsis, Elevated white blood count, Encounter for attention to tracheostomy, Dependence on respirator (Ventilator) status, and Pressure ulcer of unspecified part of back, stage 4. R124's MDS (Minimum Data Set of 3.19.2024) does not document R124's cognitive status or pressure ulcer risk. R124's current weight (4.3.2024) is 110.4 pounds. R124's Order summary report documents Low air loss mattress in use. Check for proper functioning and settings. Every shift. Order date/start date 3.30.2024. 2. On 4.20.2024 at 1:08 PM, R80 was observed resting in bed on a low air loss mattress; weight was set for 350 pounds. V2(DON) said, R80's not 350 pounds. R80's face sheet documents a [AGE] year-old admitted to the facility on 6.30.2021 with diagnoses including but not limited to: Encephalopathy, Chronic respiratory failure with hypoxia, Unspecified severe protein-calorie malnutrition, and Pressure ulcer of other site, stage 4. R80's MDS (Minimum Data Set of 3.25.2024) documents R80 is severely cognitively impaired; does not document pressure ulcer risk. R80's current weight (4.3.2024) is 160.2 pounds. R80's Order summary report documents Low air loss mattress in use. Check for proper functioning and settings. Every shift. Order date/start date 4.4.2024. 3. On 4.20.2024 at 1:18 PM, R129 was observed resting in bed on a low air loss mattress, weight was set for 280 pounds. V2 (DON) said R129 doesn't look like he weighs 280 pounds. R129's face sheet documents R129 is a [AGE] year-old admitted to the facility on 9.14.2023 with diagnoses including but not limited to: Anoxic brain damage, Cardiac arrest, Chronic respiratory failure, Encounter for attention to tracheostomy, and Dependence on respirator (Ventilator) status. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R129's MDS (Minimum Data Set of 3.25.2024) does not document R129's cognitive status or pressure ulcer risk. R129's current weight (4.9.2024) is 186 pounds. R129's Order summary report documents Low air loss mattress in use. Check for proper functioning and settings. Every shift. Order date/start 4.4.2024. 4. On 4.20.2024 at 1:32 PM, R105 was observed sitting up in bed on a low air loss mattress, weight was set for 650 pounds. R105 said, I weigh 460 pounds. R105's face sheet documents R105 is a [AGE] year-old admitted to the facility on 11.17.2023 with diagnoses including but not limited to: Acute and chronic respiratory failure with hypoxia, Acute and chronic respiratory failure with hypercapnia, Chronic obstructive pulmonary disease, Morbid (severe) obesity with alveolar hypoventilation, Type 2 diabetes mellitus with diabetic neuropathy, and chronic kidney disease, stage 1. R105's MDS (Minimum Data Set of 2.19.2024) documents R105 is moderately impaired and is at risk for pressure ulcers; no treatments listed. R105's current weight (4.10.2024) is 460 pounds. R105's Order summary report documents Low air loss mattress in use. Check for proper functioning and settings. Every shift. Order date/start date 4.4.2024 5. On 4.20.2024 at 1:35 PM, R70 was observed sitting in bed on a low air loss mattress, weight was set for 280 pounds. R70 said to V2 (DON), I weigh 217 pounds, the mattress is too hard. R70's face sheet documents R70 is a [AGE] year-old admitted to the facility on 3.1.2024 with diagnoses including but not limited to: Acute osteomyelitis, Pressure ulcer of right heel, Type 2 diabetes mellitus with diabetic neuropathy, and Acute pulmonary edema. R70's MDS (Minimum Data Set of 3.3/2024) documents R70 is cognitively intact and is at risk for pressure ulcers; pressure reducing device for bed. R70's Order summary report documents Low air loss mattress in use. Check for proper functioning and settings. Every shift. Order date/start4.4.2024. R70's current weight (4.11.2024) is 207.8 pounds. On 4.20.2024 at 1:05 PM, V2 (DON) said, a wound (pressure ulcer) could worsen if the low air loss mattress weight setting is not set to the correct weight. On 4.20.2024 at 1:48 PM, V6 (Wound Care Coordinator) said if the weight setting on a low air loss mattress is set too high or too low, the risk for pressure injuries is increased.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44314 Based on observation, interview and record review, the facility failed to follow their medication administration policy by 1) not locking the medication cart when out of sight of the medication nurse, 2) by leaving medications on top of the medication cart for 2 residents (R90 and R246) while the medication cart was in the hallway and the medication nurse was out of sight of the medication cart, and 3) leaving medications unattended at a resident's bedside (R55). Findings Include: R90's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Dysphagia following Cerebral infarction, Epilepsy, unspecified, intractable, without Status Epilepticus, Type 2 Diabetes Mellitus with Hyperglycemia, Morbid (Severe) Obesity due to excess Calories, Chronic Kidney Disease, Stage 3 Unspecified, Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Chronic Pain Syndrome, Gastro-Esophageal Reflux Disease without Esophagitis, Major Depressive Disorder, Single Episode, Unspecified. MDS section C (dated 01/24/2024) documents that R90 has a BIMS score of 15, indicating that R90's cognition is intact. Care plan (dated 01/26/2024) documents that R90 is at risk for falls due to impaired mobility/Paralysis (LUE and LLE), Gait/balance problems, Paralysis related to Hemiplegia/Hemiparesis post CVA affecting L dominant side, Chronic pain. On 04/20/2024 at 9:21am, during medication administration observation of V3 (registered nurse), surveyor observed V3 prepare a total of 18 scheduled medications (9am) for R90 with the medication cart located in the hallway, 2 rooms down from R90's room. V3 stated, I am going to put the 2 Tylenol tablets in a separate cup, in case R90 will not want them. I'll ask R90 if she wants the Tylenol when I bring the medications to her. I took the MiraLAX bottle out, but I won't pour the powder into the medication cup yet, in case R90 will not want the MiraLAX. Surveyor observed V3 separating the following medication: Acetaminophen 325mg (2 tablets) placed inside a clear medication cup (labeled 30ml) and 1 bottle of MiraLAX (17.9oz). Surveyor observed V3 walking away from the unlocked medication cart that was in the middle of the hallway and entering R90's room to administer R90's medication to R90, leaving the medication cart (identified as 2-O medication cart 2) unlocked and unattended and leaving the Acetaminophen medication and the MiraLAX bottle on top of the cart unattended. At 9:32am, V3 (registered nurse) returned to the medication cart after administering R90's medications. Surveyor inquired about the 2 medications that were left on top of the nursing cart unattended. V3 stated, No, we are not supposed to leave medications on top of the cart unattended. If we walk away from the medication cart, medications have to be put away inside the cart. We are never supposed to leave any medications unattended because it is a safety issue, and any resident can grab the medication and consume it. We are supposed to lock the medication cart when we walk away from it. When the medication cart is unattended, it has to be locked for resident safety. I left the Tylenol tablets and the MiraLAX bottle on accident, I did not mean to leave it on top of the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/2024 at 9:24am V2 (director of nursing) stated, Per facility policy, leaving the medications unattended and unsecured on top of the medication cart is not acceptable. Leaving the medications at the resident's bedside is unacceptable. Leaving the medications at a resident's bedside is a safety concern because some medications are high risk, and the resident might not take the medications, or another resident can remove the medication from the bedside, and they might consume it themselves. Leaving the medications unattended and unsecured on top of the medication cart, while the medication cart is in the hallway, is unacceptable because a resident who is ambulatory and/or confused might take the medications and swallow it and that is a safety issue. Nurses must lock the medication cart when the nurse is not in direct view of the medication cart, or when the nurse walks away. The medication cart must be locked at all times when unattended. If the medication cart is not locked and unattended, a resident can access the medication cart and potentially self-administer medications that's not intended for them. Leaving the medication cart unlocked is a safety risk for the residents in the facility. R90's Physician Order (dated 08/08/2023r) states: Acetaminophen Oral Tablet 325 MG (Acetaminophen); Give 2 tablet by mouth three times a day for pain. R90's Physician Order (dated 08/08/2023r) states: Polyethylene Glycol 3350 Powder; Give 17 gram by mouth two times a day for constipation. Medication Administration Policy (dated 10/25/2014) states: During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information by closing the MAR book/covering the MAR sheet or computer screen when not in use. 45000 On 04/20/2024 at 11:34AM, observed a medication cart (identified as the 1-O medication cart) unattended. Observed five pills inside of an unlabeled clear medication cup on top of the unattended medication cart with the following pills inside: one small, orange, round pill one small, pink, oval pill one small yellow, round pill one small white, round pill one medium, beige round pill On 04/20/2024 at 11:34AM, V10 (Agency Licensed Practical Nurse/LPN) observed approaching 1-O medication cart. Surveyor made V10 aware of the unattended medications on top of the medication cart. V10 stated he prepared the unattended medications for R246. V10 stated he is aware of what could have happened. V10 stated someone could have potentially taken the medications and ingested them and had a harmful reaction to the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy dated 05/01/2028 titled Storage of Medications documents in part, Medications and biologicals are stored safely , securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. B. Medication rooms, carts, emergency kits/boxes, and medication supplies are locked when not attended by persons with authorized access. 15301 On 4.20.2024 at 12:28 PM R55 was observed awake and alert, resting in bed. A medicine cup with four white tablets were observed on R55's over the bed table. R55 said the nurse left the pills there earlier; he wasn't going to take them because he didn't know what they are. On 4.20 2024 at 12:41 PM, when surveyor asked V8 (Licensed Practical Nurse-Agency) if she left medications at R55's bedside, V8 said, I did not. V8 accompanied surveyor to R55's room; surveyor asked V8 about the four white tablets in the medicine cup on R55's over the bed table. V8 said, It must be the ones I just gave him fifteen or twenty minutes ago. R5 said to V8, I was waiting for you to come back because I didn't know what they (pills) are, I wasn't going take them. On 4.20.2024 at 1:04 PM, V2 (Director of Nursing) said, medications should not be left at the resident's bedside. It's a safety concern; another resident or visitor could take the medicine or the resident it was given to might not take the medicine.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45000 Based on observation, interview, and record review, the facility failed to follow infection control practices and discard soiled personal protective equipment/PPE appropriately for one resident (R246). This failure has the potential to affect 16 residents residing on the same wing in a total sample of 27. Findings include: On 04/20/2024 at 11:05AM, V10 (Agency Licensed Practical Nurse/LPN) informed surveyor that he is the nurse assigned to care for all residents residing on the 1-O unit of the facility. V10 informed surveyor R246 is on contact isolation due to R246 having a diagnosis of influenza. On 04/20/2024 at 11:48AM, surveyor observed V10 exiting R246's room wearing a gown and gloves. V10 began ambulating down the hall with the potentially infectious gown and gloves on. V10 then walked back into R246's room and doffs the gown and gloves in the hallway outside of R246's room. V10 placed the gown and gloves on top of R246's isolation cart located outside of R246's room. V10 then picked the gown and gloves up off the isolation cart and transported them to the nurse's station and placed the potentially infectious PPE inside a garbage bin located at the nurses' station. Surveyor asked V10 what the protocol is for disposing of PPE after exiting a resident's room who is on contact isolation. V10 stated he did not look to see if R246 had a garbage bin located inside of R246's room for V10 to dispose the potentially infectious PPE. V10 stated he does not think it matters where he places the potentially infectious gown and gloves. Surveyor observed contact isolation and droplet isolation signage on R246's door. Contact isolation sign documents Discard gloves before room exit and Discard gown before room exit. Surveyor donned full PPE to include mask, gown, gloves, and face shield and entered R246's room. Surveyor observed a garbage bin located adjacent to R246's bed and another garbage bin located inside of R246's bathroom inside of R246's room. On 04/22/2024 at 12:45PM, V2 (Director of Nursing/DON) stated that for residents on contact isolation with droplet isolation, staff should don appropriate PPE when entering a resident's room and should remove PPE prior to leaving the resident's room. V2 stated the PPE should not be worn outside in the halls or in common areas of the facility. V2 stated there is a potential risk of transmitting the infectious disease of the infected resident to others when PPE is worn outside the resident room and in the common areas. Facility census dated 04/20/2024 documents a total of 16 residents resides on the 1-O unit of the facility. Facility policy undated titled Contact Precautions documents in part, Purpose: To prevent the spread of infection within the facility through the use of Contact Precautions with residents when appropriate. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. The gown should be removed before leaving the resident's room.