STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145662	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Niles	8333 West Golf Road 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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32115 Based on observation, interview, and record review the facility failed to ensure the safety of resident by not having two staff members provide personal care for 1 of 3 residents reviewed for abuse/injuries of unknown origin in the sample of 14. The findings include: R2's Physician Order Set dated 9/7/24 shows diagnoses to include: Wedge compression fracture of unspecified lumber vertebra, unspecified osteoarthritis, hemiplegia with hemiparesis following cerebral infarction affecting the right dominate side, unspecified dementia without behavioral disturbance, nondisplaced fracture of the upper end of the right humerus, long term use of opiate analgesic. R2's progress noted dated 8/22/24 at 3:59PM shows resident sent out to ER for further evaluation R humerus acute fracture per x-ray result. Sent back today, with sling on R arm and dx of non-displaced R humerus fracture . R2's facility assessment dated [DATE] shows she is cognitively impaired. R2's Restorative assessment dated [DATE] shows R2 has an impairment to her upper extremity on one side and has an impairment to the lower extremity on both sides. This assessment shows R2 is dependent on staff for toileting, showering/bathing. R2 requires substantial/maximal assistance. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. R2's care plan with a target date of 9/5/24 shows she is at risk for falls due to ADL dependence, decreased mobility related to weakness, and diagnoses of CVA, right hemiplegia/hemiparesis, and wedge compression fracture of the lumbar vertebrae. R2's alteration in musculoskeletal status care plan related to history of fracture and diagnoses of osteoarthritis (OA) with a target date of 9/5/24 shows that R2 will remain free of injuries or complications. R2's functional deficit in bed mobility care plan with a target date of 9/5/24 shows [R2] will turn side to side with verbal cues and substantial/max assist. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/7/24 at 1:52PM, V16 (Certified Nurse Assistant-CNA) was in the room with R2, and said she was giving her a bath. R2's bed was raised up off the floor. R2 was undressed in bed, no sling to her right arm. R2's right arm was bent at the elbow with her hand resting on her chest, and her thumb turned inward. R2 had a dark, fading brownish bruise to her right mid arm extending below her elbow. R2's elbow appeared swollen. R2 had a small fading yellow/brown bruise to her right chest area, approximately 2 inches in length. V16 rolled R2 on her right side (injured side) away from her, to remove the soiled linens and apply a clean sheet and incontinence pad. V16 held R2 on her side with V16's arm partially extended and R2 held on to the rail. V16 placed R2 on her back and R2 continued to hold her right arm with her left hand. Her right arm remained sitting across the front of her chest. V16 then helped move her to the center of the bed using the incontinence pad, pushing her towards the right side of the bed. R2 reached for the rail with her left hand and tried to help. R2 was turned on her left side by V16 to remove the linens and pull the clean linens through. R2 was not able to move her right hand to assist with turning. V16 held her on her side with her hand on R2's back/shoulder and her arm partially extended. V16 helped R2 return to her back. V16 left the bed in the raised position, and left the room to get a gown for R2. R2 used her left arm to raise her right arm while V16 put the new gown sleeve on her right arm. After putting the gown on R2 said all done and V16 said she needed help to position her in bed. R2 asked for her hair to be combed, and V16 left the room to get a comb. R2's bed was left in the raised position. V28 (CNA) came into the room, and V28 and V16 used the incontinence pad to lift R2 higher in bed. V16 said she did not know how to put the sling on R2, and she took it off to give her the bath. V16 said she raised the bed when came in the room (to give care) and will lower it when she is done. On 9/7/24 at 10:52AM, V28 said R2's right arm is normally weak. R2 uses her left arm to move her right arm. V28 said no prior to the fracture, R2 did not have use of her right arm. V28 said R2 requires a two person assist, always. V28 said yes R2 requires a two person assist with incontinence care and needs two people to help her during the night. On 9/7/24 at 11:25AM, V16 said R2 is sometimes confused but they never have issues when caring for her. R2 will say things that don't make sense, but she has never seen her with behavior issues. V16 said R2 is total care and is a two person assist. R2 needs two staff for incontinence care, and repositioning. V16 said R2 always stays on her left side and leans against the rail with her left side. V16 said R2's right arm is contracted, and she uses her left arm to move the right arm. V16 said there is only one CNA on night shift, she is not sure how they provide care for R2. V16 said yes there are usually 2 people providing care. On 9/9/24 at 3:00PM, V14 (Registered Nurse) said she cares for R2. V14 said R2 is forgetful and requires assistance from staff with changing her incontinence brief, and bed baths. She needs assistance with meals but can feed herself. V14 said prior to R2's fracture, she was a one staff assist, and since the fracture, she requires a two staff assist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/7/24 at 2:14PM V2 (Director of Nursing) said R2 recently had a fracture to her Right arm. They do not know what happened, but they are attributing it to her right hemiplegia, and atrophy due to her bones not moving. At 2:14PM, V2 said R2 needs assistance from 2 staff members for ADL care, repositioning, and bathing. V2 said it is more difficult to roll R2 on her right side and a bed bath would require two people. V2 said R2 is not able to assist with her right side, she can only assist with her left, and not using two people could cause her more pain. V2 said R2's right side is flaccid, and the CNAs know the level of care required because it is in the computer. V2 said in the computer it shows special instructions total assist of two staff. V2 said the staff don't always want to wait for assistance from a second person. On 9/9/24 at 10:10:AM, V22 (Physician) said R2's (right) side of her body is so atrophied that her body weight could cause her arm to fracture. V22 said one staff should be able to provide care for her, the staff know they are not supposed to push or pull from that side of her body.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure a residents medications were available and administered on time for 1 of 3 residents (R1) reviewed for medications in the sample of 14. The findings include: On 9/7/24 at 9:34 AM, R1 was lying on bed with a heating pad on his lower back. R1 said he's been having issues with a specific medication, Prazosin. R1 stated, It's a sleep aide that helps prevent my nightmares. I have PTSD (Post Traumatic Stress Disorder). R1 said this medication is frequently given late and wasn't given a couple of days. R1 said he is a nurse and knows how medications should be administered. R1 said if he doesn't get his medications as scheduled, it can make him loopy. R1 said he's not sure what the problem is, but it seems like poor time management. R1's Facesheet dated 9/7/24 showed diagnoses to include, but not limited to: prostate cancer, lumbar disc displacement, hypertension, major depressive disorder, anxiety, PTSD, and vitamin D deficiency. R1's Physician Order Sheet dated 9/7/24 showed an order for Prazosin 6 mg (milligrams) at bedtime for PTSD and nightmares. R1's August 2024 MAR (Medication Administration Record) showed R1 received 3 - 2 mg tablets for each dose at 9 PM. This document showed R1's Prazosin was not administered on 8/19/24 and 8/20/24. The medication is documented as NA = Not available. R1's Prazosin Resident Details report showed that he received 14 of 31 doses late (greater than 1 hour after the scheduled time of 9 PM). The facility provided a Packing Slip Proof of Delivery form dated 8/6/24 at 11:26 PM. This form showed R1 had 90 capsules of Prazosin delivered (this supply should have covered 30 days). R1's Pharmacy Phone Reorder Form showed on 8/20/24 at 7:49 PM the facility called to have R1's Prazosin refilled and the pharmacy noted that the facility must complete a too soon form, and pay. The facility provided a Packing Slip Proof of Delivery form dated 8/21/24 at 6 AM. This form showed R1 had 90 capsules of Prazosin 2 mg delivered. On 9/7/24 at 9:55 AM, V3 (RN - Registered Nurse) said medications should be administered within one hour before and one hour after the scheduled time. V3 said if there are issues with medication administration, refusals, or missing medications the nurse should document a note in the MAR and/or in the progress notes. V3 said the pharmacy supplies the medications in a bingo card format. V3 said at the end of each bingo card, there are pills outlined in blue and it states, Reorder. V3 said the nurse can reorder medications through the EMR (Electronic Medical Record), by calling the pharmacy, or sending a fax with all the pertinent information. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/7/24 at 2:49 PM, V9 (RN) said he changed NA on R1's Prazosin on 8/20/24 because the medication was not in the medication cart or in the medication room. V9 stated, All I can tell you is I didn't have the medication. I had to order some. On 9/9/24 at 9:30 AM, V29 (Pharmacist) said Prazosin in commonly used as a blood pressure medication, but has off-label uses for PTSD. V29 said the medication should be administered within one hour of the schedule time. V29 said delayed or missing doses could cause R1 behavior and/or psychological distress. The surveyor asked V29 to review the pharmacy records for R1's Prazosin. V29 said a 30 day supply (90 capsules) was delivered to the facility on [DATE]. V29 said that supply should have been enough to cover beyond 8/19/24 and 8/20/24. V29 said there was a second delivery on 8/21/24 for another 30 day supply. V29 said there is a note in our system that R1's Prazosin was ordered too soon, the facility had to complete a form and agreed to pay for the early refill. On 9/9/24 at 2:30 PM, V2 (DON - Director of Nursing) said the facility policy is to administered medications within one hour of the scheduled time. V2 said she noticed that R1 had several late doses and she would be talking to the nurses. V2 said missed or delayed administration could cause issues for R1. V2 said he may have behavioral issues or trouble sleeping. V2 said the indication for R1's Prazosin was PTSD and nightmares. V2 said she didn't know why the nurses couldn't find R1's Prazosin. V2 said there should be more documentation in the MAR or progress notes regarding late administration, refusals, and medications not being available. (R1's Progress notes did not provide any additional information regarding the 14 late doses and the 2 days marked NA.) The facility's Medication Administration Policy dated effective 10/25/14 showed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions . Procedures: .B. Administration . 2. Medications are administered in accordance with written orders by prescriber . 6. Medications are administered without unnecessary interruptions . 12. Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on meal times . C. Refusals of Medication . 5. Medication refusal must be reported to the prescriber after (XX) number of doses are refused and there must be documentation of prescriber notification of such. D. Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR directly after medication is given . 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time . If an electronic MAR system is used, specific procedures required for resident identification, identifying the medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user manual. These procedures should be followed, and may differ slightly from the procedures for using paper MARs .