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	02/10/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33783 Based on interview and record review, the facility failed to follow a provider order for a STAT (immediately) x-ray to be completed for a resident after a fall. This failure applied to one (R1) of three residents reviewed for accidents and resulted in R1 having a delay in being transferred to the hospital for evaluation and treatment of a fractured hip, which required surgical intervention. Findings include: R1 is a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses that include: right femur fracture; unspecified dementia, moderate, w/out behavioral disturbance, psychotic disturbance, psychotic disturbance, mood disturbance, and anxiety; and mild cognitive impairment. Fall Report dated 1/24/25 3:34pm written by V8 (Licensed Practical Nurse / LPN) reads: Incident Description: Writer heard residents in the dining room yelling. When writer got to the dining room to assess what was going on the patient (R1) was noted laying on the floor on her right side while other resident (R2) was standing over her. Floor was noted dry and free of clutter. Noted walker was next to resident at the time of the incident. Immediate Action Taken: Patient was assessed from head to toe and was given pain medication and helped back to her room. NP (V9-Nurse Practitioner) assessed resident and ordered right hip x-ray and bilateral shoulder x-ray .Patient reported having pain in her right hip. There was no bruising or shortening of her legs . Mobility: Ambulatory with assistance Nursing progress notes read the following: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	1/24/2025 3:58pm Nurses Note written by V8 (LPN) reads: Note Text: Writer heard residents in the dining room yelling at each other. When writer got to the dining room to assess what was going on the patient (R1) was noted laying on the floor on her right side while other resident (R2) was standing over her. Writer checked residents vitals and is as follow; bp (blood pressure) 126/86, rr (respiratory rate) 18, p (pulse) 71, o2 (oxygen saturation) 98%. Pupils equal and reactive and same size and no weakness bilateral, Patient reported having pain in her right hip. There was no bruising or shortening of her legs. Resident was assisted back to her room and given pain medication. The administrator was informed and the (V9) NP was informed. (V9) NP assessed patient and asked writer to order right hip x-ray and bilateral shoulder x-ray. All orders carried out. Administrator informed writer that she would contact family. Patient was assisted into bed and made comfortable. HOB (head of bed) raised and call light within reach. 2/08/2025 at 6:08PM V10 (Registered Nurse/RN) said, I have worked here almost a year. On 1/24/25 I worked 3-11pm. During that time, the morning nurse endorsed to me that there was an incident that another resident pushed R1 and that's why she fell . They ordered an x-ray. The morning nurse ordered the x-ray. Surveyor asked V10 if the x-ray company was called to find out the status. V10 responded, yes and they said that they would come but I don't remember them giving me a time frame. If an x-ray is ordered STAT (immediately) it should be ordered within 30 minutes to one hour. Since they said they would come, I endorsed it to the next nurse for them to follow-up again. Surveyor asked if it was expected that the x-ray company would not come within the timeframe of the eight hour shift that V10 worked. V10 said, no, I know it should have been done sooner. I don't remember what time I followed up with them. When asked if anything should have been done differently, V10 said, maybe I would have followed up again and informed the supervisor and then maybe we could have sent the patient to the hospital. During my assessment with her she was sleeping at first. Towards the end of the shift, I checked her again, I touched her left and right back and you could notice that she was in pain. The first thing I did was put the Lidocaine patch and give Tylenol since those pain orders were already in the system. V10 affirmed that she did not call the doctor to notify them that R1 was having pain but did endorse it to the oncoming nurse; because it was towards the end of V10's shift already. V10 added, I did assess her lower extremities and I didn't see any swelling or shortening of the leg. She (R1) was quiet, but she had facial grimacing when I touched her back. I applied the Lidocaine patch to her back. V10 said, sometimes when I call (x-ray company) they give a rough estimate but not an exact time. They may say we'll be there in the morning or evening but not an exact time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2/8/25 at 6:20PM V11 (LPN) said, I have worked at the facility about 14-[AGE] years. I normally work the overnight shift. I remember that the 3-11 nurse told me that R1 had a fall and that we were waiting for the x-ray company to come and take the x-ray. I made rounds and she was in bed sleeping so I did not touch her. When I made rounds again, she had her eyes open, and I asked her if she was in pain. She is hard of hearing, so I checked her leg. When I moved her leg, she made a noise and verbalized ow. I noticed the swelling and I called V2 (Director of Nursing/DON) and the doctor right away to tell them that I had to send her to the hospital. I called the x-ray company and they said they were on their way but with the swelling and the little bit of external rotation I did not want to wait for the x-ray company. I left a message with the doctor, called her POA (Power of Attorney), and notified V2 (DON) that I had to send R1 out. I called the ambulance, and they were here within 10 minutes. For x-rays that are ordered STAT, I don't really encounter that problem (with delays) because I work night shift so there are not a lot of incidents because the residents are sleeping. My expectation as a nurse is that if it's a STAT x-ray they come soon. I don't think that I would wait eight hours for a STAT x-ray; so, they should come right away. I would follow up again and see if they are really coming to do the x-ray and if they still are not coming and it's a fall, I would have to use my judgment as a nurse. If I notice something unusual, I will call the doctor, Director of Nursing, and POA right away to send the patient to the ER. I did my part as the nurse on duty. I know the assessment is very important as a nurse, especially when the patient has had a fall. I always make sure that I check them right away and do frequent rounds because they might not have a visible injury right away, but you never know. You might think there is nothing wrong and then later on you see something. I always ask the CNA (Certified Nurses Assistant) for help because if they are sleepy, they may hit you or something because it is a dementia unit. 2/08/2025 at 5:06PM V2 (DON) said, since R1 hasn't had a fall for years she can be independent. The reason we have her as supervision (on MDS) is more for incontinence because she needs assistance to the bathroom. Again, she hasn't had any falls. When she doesn't have an infection, her ambulation is quite good. For us, the concern was because of the UTI (urinary tract infection) and the COVID with this fall. She walks around in the morning and in the afternoon but it's not realistic for us to have a one to one. Someone is always there. There is always staff monitoring them. Someone always has to be visible in the hallway, but they can't just be sitting in the dining room. It has to be something that's going to work for all residents. I can't restrain her. She is safe to walk around with the walker. If we order a STAT x-ray, it should be done within a 4-6-hour window and we do call that in after we call the nurse practitioner. We noticed there was swelling in the right leg, and we notified the doctor. At 10:38pm it was the left right back where she was having pain. No mention of swelling. If the x-ray isn't done within 6 hours, we call the doctor to send them out to the hospital. If it's not STAT, then waiting 24 hours is okay. (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 0684 Level of Harm - Actual harm Residents Affected - Few	2/8/25 at 3:20PM V9 (NP) said, I wasn't a witness to the incident. I just remember that it was unclear circumstances. She fell and broke her hip and required an ORIF (Open Reduction and Internal Fixation - (ORIF) is a type of surgery used to stabilize and heal a broken bone). Typically, those x-rays are ordered STAT (immediately) but I'm not sure what time the x-ray was done. V9 was asked if she would expect the facility to wait 12 hours for a STAT x-ray to be done. V9 said, if the patient was not feeling well, I would have expected it a lot sooner or the patient sent out. The nurses told me she was pain free and I didn't think she had broken that hip based on how she looked really. But if the nurses assessed and she was not in pain I could understand why she wasn't sent out sooner. When I saw her (immediately after the fall), she was stable, and I asked if she had any pain and she said no. It could have been pain from the fall and if they knew the x-ray department wasn't coming in time then of course they should not wait. As much as I wish they would come sooner, we are at their (x-ray company) mercy. For a STAT x-ray, I would ideally like it done within the hour but at least 3-5 hours. Review of R1's hospital record documents that R1 was admitted on [DATE] for a right, closed, hip fracture. Physical exam documents that R1's right hip was externally rotated, pulses intact and pain with movement of the hip. Hospital x-ray confirmed partially impacted right femoral neck fracture; mild to moderate displaced fracture of the right superior and inferior pubic rami. Hospital record also documents that R1 had sepsis, urinary tract infection, pneumonia, COVID-19, and leukocytosis present on admission, in addition to the fracture. Facility policy titled, Physician Notification of Laboratory/ Radiology/Diagnostic Results (last revised 7/8/24) reads: Purpose: To assure physician ordered diagnostic test are performed, and to assure test results are reported to the ordering 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. A requisition is to be completed and lab to be drawn on next scheduled lab draw day UNLESS Stat or Same Day order is received. oCollect and label specimen, name, date, time and name of test. Place in plastic transport bag - note stat. oCall for transport service. 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. Laboratory and/or diagnostic company will contact assigned licensed nursing staff with any abnormal or critical results that require prompt attention. Test results should be reported to the primary care physician or other ordering practitioner pursuant S483.50 Laboratory, radiology, and other diagnostic services guidelines. Guidelines for Reporting Abnormal Results: o All Critical laboratory values - also called Alert or Panic values (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	o X-ray or other diagnostic tests reveal suspected findings which may require immediate intervention including but not limited to: o Pneumonia o New fracture 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. For example, some conditions may require immediate 911 intervention, others may be delayed 4 or more hours if the condition of the resident is stable. Should the alternate physician or Medical Director not respond, the Director of Nursing will be notified. The Director of Nursing interventions should include: o Assessment of the resident's clinical condition (in person or by phone) o Further attempt to contact the Physician, Alternate Physician or Medical Director o Emergency transfer based on clinical judgement .

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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 0689 Level of Harm - 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** 33783 Based on interview and record review, the facility failed to provide supervision/touching assistance for a resident when moving from a seated to standing position, per the residents plan of care and assessments, in order to prevent a fall. This failure applied to one (R1) of three residents reviewed for accidents and resulted in R1 having a fall causing a fractured hip that required surgical intervention. Findings include: R1 is a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses that include: right femur fracture; unspecified dementia, moderate, w/out behavioral disturbance, psychotic disturbance, psychotic disturbance, mood disturbance, and anxiety; and mild cognitive impairment. R1's Minimum Data Set (MDS) assessments document the following: 1/4/25 Section GG Functional Abilities codes R1 as requiring supervision or touching assistance during sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed); walk 10 feet (once standing, the ability to walk at least 10 feet in a room, corridor, or similar space); walk 50 feet with two turns (once standing, the ability to walk at least 50 feet and make two turns); walk 150 feet (once standing, the ability to walk at least 150 feet in a corridor or similar space). Fall Report dated 1/24/25 3:34PM written by V8 (Licensed Practical Nurse / LPN) reads: Incident Description: Writer heard residents in the dining room yelling. When writer got to the dining room to assess what was going on the patient (R1) was noted laying on the floor on her right side while other resident (R2) was standing over her. Floor was noted dry and free of clutter. Noted walker was next to resident at the time of the incident. Immediate Action Taken: Patient was assessed from head to toe and was given pain medication and helped back to her room. NP (Nurse Practitioner) assessed resident and ordered right hip x-ray and bilateral shoulder x-ray .Patient reported having pain in her right hip. There was no bruising or shortening of her legs . Mobility: Ambulatory with assistance Nursing progress notes read the following: (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 0689 Level of Harm - Actual harm Residents Affected - Few	1/24/2025 3:58PM Nurses Note written by V8 (LPN) reads: Note Text: Writer heard residents in the dining room yelling at each other. When writer got to the dining room to assess what was going on the patient (R1) was noted laying on the floor on her right side while other resident (R2) was standing over her. Writer checked residents vitals and is as follow; bp (blood pressure) 126/86, rr (respiratory rate) 18, p (pulse) 71, o2 (oxygen saturation) 98%. Pupils equal and reactive and same size and no weakness bilateral, Patient reported having pain in her right hip. There was no bruising or shortening of her legs. Resident was assisted back to her room and given pain medication. The administrator was informed, and the NP was informed. NP assessed patient and asked writer to order right hip x-ray and bilateral shoulder x-ray. All orders carried out. Administrator informed writer that she would contact family. Patient was assisted into bed and made comfortable. HOB (head of bed) raised and call light within reach. 2/7/25 at 3:38PM V7 (Certified Nursing Assistant / CNA) said, I was standing by room [ROOM NUMBER]; not in the dining room. I was supervising the unit. R1 and R2 were having a verbal disagreement. I saw R1 put her hand on the walker to get up and the walker tipped over and she fell on the right side. At no point did I see R2 hit R1 or R1 hit R2. The nurse then came, and the other CNA came to help. No issues with either of them being aggressive with other residents. There were no other residents in the dining room at that time. 2/8/25 at 1:13PM V8 (LPN) said, I have worked here since May 2024. I normally work on the second floor but recently I have been floating around. Regarding the incident with R1 and R2, I was at the nurses station charting and I heard a commotion. I went to the dining room and R1 was on the floor. R2 was in the room, right next to her or over her. I don't remember exactly. The dining room is not in view of the nurses' station. I think they were right when you first go into the dining room. I don't recall any other residents being in there are the time. When I got there the CNA (V7) was there. I don't remember her name because I don't work with her that often, but it wasn't CNA (V4) because I know her, so yes it was V7 and then V4 came in after. R1 was hysterical and saying, I fell . I was asking her what happened, but she was just saying that her leg hurt. I just examined her, and we helped her get up and I called V1 (Administrator). R1's walker was in there with her. I usually see her getting up independently and she walks over to the dining room with her walker, sometimes I'll see her by the nurses station. Surveyor asked V8 if she would have expected someone to be in the dining room monitoring R1 and R2. V8 responded, there is usually someone in there monitoring. I know that around that time of day, a lot of them like to walk around. Right before the shift ends there are rounds and I am usually charting getting ready to go home. I don't know if the CNA was in there the entire time. She didn't report anything specific to me. I had to open my charting, call V1 (Administrator) and the Nurse Practitioner (NP). When I did go to get a statement from V7, I couldn't find her. I assumed she had left for the day. The NP ordered the x-ray. We helped R1 to her room and then right after that, the NP came to the floor and assessed her as well. Surveyor asked, what type of supervision is expected for a resident who has an MDS code of (4) Supervision / Touching Assistance. V8 said, I would say that you have to guide them and be there when they are getting up so if they look weak you may have to provide them with more assistance than usual. A lot of times they get up on their own, but you have to watch them. I would expect for someone to be around them when they are getting up from the bed or chair. I would probably say staff should be within eye length distance; within your view. I have never seen R1 get aggressive. I have heard about R2 getting aggressive, but I have never witnessed it; he may touch things or move things around; or he can get close to you. Again, I haven't experienced that with him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/7/25 at 2:03PM, V3 (LPN) said she was not present during the incident with R1 and R2. V3 said that the residents must always be monitored because this is a dementia unit. Some people can be more agitated, and we have to monitor them closely and they can fall. Safety is the priority. V3 added that she has not witnessed any abuse between R1 and R2 but that R1 can get mad at times, and she is hard of hearing so she can get frustrated. 2/7/25 at 2:17PM, V4 (CNA) said, I was here during the incident with R1 and R2, but I was in the room with another resident. R2 was out for a few months but he is calm now and seems to have gotten better actually. Someone is in the dining room at all times; the residents can fall. If activities is in the dining room, they will monitor them too. 2/7/25 at 2:34PM V2 (Director of Nursing) reviewed facility fall report with surveyor. V2 added that they were not aware that R1 had COVID at the time of the fall, until the hospital called to report it to them. There are cameras in the dining room, but you can ask V1 (Administrator) to see it. All of the progress notes and assessments are in the chart. 2/7/25 at 2:45PM V1 (Administrator) said there is no video to see currently because the cameras loop every 48 hours. V1 added, I didn't get a chance to look at the video. I had left early that day because I had just gotten back from vacation. This was our only incident for January. I unsubstantiated the abuse. I initially reported it as abuse because the nurse (V8) said she didn't know what happened but assumed R2 pushed R1. During my investigation though, V7 (CNA) said she saw when R1 fell and that R2 had not pushed her. V7 said she was walking towards the dining room and could not get to R1 before she fell . When I tried to interview R1, she said she couldn't hear me, and she was confused. The combination of COVID and UTI (urinary tract infection) explain a lot about why she fell . V1 added that R1 is normally very careful when getting up but that having the infections contributed to the fall. It had been a while since R1 had any falls or infection. 2/08/2025 at 5:06PM V2 (Director of Nursing) was interviewed, and surveyor asked if R1 should have been supervised when getting up from the chair or had supervision while in the dining room since her MDS has her coded as requiring supervision and/or touching assistance. V2 said, since R1 hasn't had a fall for years she can be independent. The reason we have her as supervision is more for incontinence because she needs assistance to the bathroom. Again, she hasn't had any falls. When she doesn't have an infection, her ambulation is quite good. For us, the concern was because of the UTI and the COVID with this fall. She walks around in the morning and in the afternoon but it's not realistic for us to have a one to one. Someone is always there. There is always staff monitoring them. Someone always has to be visible in the hallway, but they can't just be sitting in the dining room. It has to be something that's going to work for all residents. I can't restrain her. She is safe to walk around with the walker. 2/8/25 at 7:10PM V1 (Administrator) said, V7 (CNA) was standing in front of room [ROOM NUMBER] and if she had been in the dining room, she would not necessarily have been any closer to the resident. We will send you a picture of the distance from the room to the dining room entrance where the residents were at the time of the fall. She was about 5 feet from the resident at the time of the fall. Review of R1's care plans include: High Risk for Falls, Initiated: 2/18/21, Revised: 2/7/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions: Needs activities that minimize the potential for falls while providing diversion and distraction (Initiated: 2/18/21); Be sure call light is within reach and encourage (R1) to use it for assistance as needed (Initiated: 2/18/21) (R1) presents with a functional deficit in ambulation due to: generalized weakness, Initiated and Revised: 4/5/21 Interventions: Staff to assist as needed (Initiated: 4/5/21); Observe for signs/symptoms of fatigue, SOB (shortness of breath), pain, discomfort, or intolerance (Initiated: 4/5/21) (R1) has an ADL Self Care Performance Deficit related to Dementia and dx of HL, HTN (hypertension), and h/o (history of) UTI, Initiated and Revised: 2/18/21 Interventions: Encourage (R1) to use bell to call for assistance (Initiated: 2/18/21). R1's restorative observation - quarterly review, dated 11/12/24 documents that R1 has Maintained ability to ambulate 100-200 feet using rolling walker with staff supervision .Resident AO (Alert and Oriented) x1-2, able to express needs, able to feed self, able to follow simple command, continent of bowel, occasionally incontinent of bladder, ambulatory with supervision touching assist using rolling walker .Resident with ADL (Activities of Daily Living) Self Care Performance Deficit related to generalized weakness, unsteady gait and poor safety awareness. Resident requires supervision to partial assist to safely complete ADLs . R1's fall risk assessment dated [DATE], documents that R1 is high risk for falling, with a weak gait and mental status limitation of overestimates or forgets limits. 2/8/25 at 3:20PM V9 (Nurse Practitioner) said, I wasn't a witness to the incident. I just remember that it was unclear circumstances. She fell and broke her hip and required an ORIF (open reduction and internal fixation (ORIF) is a type of surgery used to stabilize and heal a broken bone). Review of R1's hospital record documents that R1 was admitted on [DATE] for a right, closed, hip fracture. Physical exam documents that R1's right hip was externally rotated, pulses intact and pain with movement of the hip. Hospital x-ray confirmed partially impacted right femoral neck fracture; mild to moderate displaced fracture of the right superior and inferior pubic rami. Hospital record also documents that R1 had sepsis, urinary tract infection, pneumonia, COVID-19, and leukocytosis present on admission, in addition to the fracture.