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	10/04/2024

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 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** 39781 Based on observation, interview, and record review the facility failed to provide privacy and dignity to a totally dependent and cognitively impaired resident. This deficiency affects one (R208) of three residents in the sample of 30 reviewed for Resident's rights. Findings include: R208 was admitted on [DATE] with diagnoses listed in part but not limited to Acute and chronic respiratory failure with hypoxia, dependence on ventilator, Hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side, Tracheostomy, Gastrostomy. On 10/1/24 at 11:57AM, R208 was observed lying in bed sleeping, leaning to the left side of the bed. He was exposed and uncovered wearing a gown and disposable brief. His body from his abdomen to lower extremities were exposed. A folded linen sheet was seen on the left corner side of the bed. The left heel protector was on the floor. The right heel protector was not properly placed. R208 was wearing bilateral hand mittens. The door was open and R208 was visible to any passerby walking in the hallway. The room is close to and can be viewed from the nurses station. Staff were observed at the nurses station and in the hallway. V15 (Nursing Supervisor) was showed observation. V15 said that R208 should be covered with linen for privacy and dignity. V15 took the folded linen from the corner of the bed and spread it to cover R208. On 10/1/24 at 1:30PM, Informed V1 (Administrator) and V2 (Director of Nursing) of above concern. Requested for policy. Facility's policy on Resident Rights reviewed 1/4/19 indicates: Purpose: To promote the exercise rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: (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
	145662	A. Building B. Wing	10/04/2024

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Exercise his or her rights. *Privacy and confidentiality.

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on interview, and record review the facility failed to obtain discharge orders from the physician to transfer a resident (R154) to another facility and failed to provide a discharge summary to the continuing provider and receiving facility at the time of discharge. This deficiency affects one (R154) of one in the sample of 30 reviewed for Discharge summary. Findings include: A review of R154's records show that R154 was admitted on [DATE] with diagnoses of Cellulitis of right lower limb, Unsteadiness on feet, Acute post hemorrhagic anemia and long-term use of antibiotics. R154 was identified as elopement/unauthorized departure risk on 9/25/24 indicated: A Evaluation: Resident have the physical ability to leave the facility; Resident verbalize anger and or a serious intent to leave the facility and has a history of unauthorized departure; Resident seek exits, pull door handles, hang around facility exits and stairways or wanders between floors; Resident becomes easily agitated, confused, and or disoriented and show poor judgement (wound not be able to safely care for him/herself outside of the facility); B. Outcome and recommendations: R154 is considered at risk for unauthorized departure/elopement/flight risk. The resident is considered at risk for unauthorized departure. Resident will be placed on elopement watch. R154's progress notes were reviewed. On 10/1/24, a progress noted was entered by V25 (LPN/Licensed Practical Nurse) that documents that R154 was out on pass at 9:13AM, then V32 (Social Service) documented that R154 was discharged to another facility at 12:13PM. V32 documented as if the resident was in the facility when discharged to another facility. R154's active physician order did not have discharge orders. There were episodes documented of R154's behavior and verbalization of leaving the facility on 9/25, 9/26 and 9/27/24. No monitoring elopement documentation was found in the chart. On 10/2/24 at 9:25AM, V1 (Administrator) said that R154 reported that he has eloped from the facility on 9/30/24 around 11:15PM. Elopement incident was done on 10/1/24 at 6:54AM. R154's friend and police officer were notified. R154's friend found him in a shelter home and took him to another facility of his choice. V1 said that R154 was a planned discharged to the facility he was transferred to. On 10/2/24 at 10:54AM, V32 (Social Service) said that he documented the discharge notes for R154 even though he was not in the facility. V32 said that it was a planned discharged to another facility of his choice. R154 had eloped from the facility and was found by his friend in a shelter home and brought him to the facility where he supposed to be transferring. On 10/2/24 at 11:28AM, V34 (Primary Care Physician) of R154 said that she was not aware that R154 eloped from the facility on the evening of 9/30/24 and was transferred to another facility. V34 said that R154 is homeless and was denied by the other facility. Only this facility accepted him, and he needs medical treatment. V34 said that she would expect the facility to notify her when R154 had eloped and transferred to another facility. V34 said that she did not give an order for him to be transferred to another facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elevate Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 8333 West Golf Road Niles, IL 60714	

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 11:52AM, V35 Administrator and V36 Admission Director of another facility where R154 was transferred said that R154 was dropped off by his friend to their facility. They are not aware that R154 had eloped from the facility. No discharged instructions and resident's personal belongings received. They called V32 Social Service to fax documents of R154 to their facility. R154's progress note by V32 (Social Service) dated 10/1/24 at 12:13PM, documented R154 was admitted on [DATE] and V32 assisted R154 with finding another nursing home due to resident stating this nursing home not meeting his medical needs and requesting to transfer to a nursing home in Chicago. R154 was discharged and this facility arranged for transportation to another nursing home facility on 10/1/24. R154 did not show any signs or symptoms of depression or manic episodes or behaviors. R154 was re-educated on safety, home needs and medical requests, including proper nutrition, medical advice, medication usage and side effects, doctor needs and all information pertaining to R154's health and well-being relative to discharge. R154 was asked if they needed any additional medical services. R154 is stable upon discharge. The resident was asked if they needed any additional medical information, help and or education on medications/prescriptions by nursing staff. The resident expressed that he is excited to be transferred to a nursing home and happy to be discharged to pursue individual goals. Social service will follow up and provide support as appropriate. On 10/3/24 at 9:27AM, Informed V32 (Social Service) that he wrote the discharge notes for R154 without a physician order of discharge to another facility. V32 did not document that R154 had eloped from the facility, went to shelter care, and was brought by R154's friend to another facility. Instead V32 charted that R154 was discharged from this facility and was transferred to another facility. V32 did not see nor spoke with R154 on 10/1/24. V2 (DON/Director of Nurses) said that they cannot document discharge summary if the resident is not in the facility. V2 said that nursing staff will usually write the discharge narrative which includes resident clinical condition/status/stability, vital signs, medications and treatment instructions, personal belongings, medical equipment, transportation arrangements and discharge instructions. V2 said that a discharge order should be obtained from the physician before they can discharge resident. On 10/3/24 at 2:20PM, V1 (Administrator) said that they don't have policy on Discharge summary. Facility unable to provide policy on discharge summary.

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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 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** 39781 Based on observation, interview, and record review the facility failed to follow manufacturer's instruction in using low air loss (LAL) mattress by using multiple layers of linens for residents with pressure ulcers and at high risk for skin impairment. The facility also failed to apply bilateral heel protectors as ordered by physician and care plan intervention. This deficiency affects all five (R62, R100, R104, R112 and R208) residents in the sample of 30 reviewed for Pressure ulcer prevention management. Findings include: 1. On 10/1/24 at 11:57AM, R208 was observed sleeping, lying in bed leaning to the left side of the bed. He was exposed and uncovered. He was wearing gown and disposable brief. His body from abdomen to lower extremities were exposed. A folded linen sheet placed at the left corner side of the bed was seen. The left heel protector was on the floor. The right heel protector was not properly placed. R208 was wearing bilateral hand mittens. V15 (Nursing Supervisor) was showed observation. V15 said that R208 should have bilateral heel protectors in place. R208 was admitted on [DATE] with diagnosis listed in part but not limited to Acute and chronic respiratory failure with hypoxia, Tracheostomy, Dependence of respirator(ventilator), Hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side, Dysphagia, Gastrostomy, Stage 4 Pressure ulcer of sacral region. Active physician order sheet indicates heel protecting devices or offload to bilateral heels. Wound care: Left and right heel- cleanse with normal saline, apply skin prep cover with bordered gauze or foam dressing 3x/week and as needed. May cover with abdominal wrap with kerlix if gauze or foam does not stay. Comprehensive care plan indicates: R208 has pressure injury to sacrum extending to right buttocks, bilateral heels and right side back is at risk for delayed wound healing and is at very high risk for further alteration in skin integrity. Intervention: Off load heels using heel protecting devices. 2. On 10/1/24 at 11:59AM, R62 was observed lying in bed with LAL mattress. V15 (Nursing Supervisor) lifted the linen covering R62. A flat sheet and cloth pad was observed under R62 on the mattress. R62 is wearing a disposable adult brief. V15 said that residents on LAL mattresses should only have a flat sheet over the mattress, no cloth pad. R62 was admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure, Tracheostomy, Dependence on Respirator, Gastrostomy, Cerebrovascular disease (CVA), Encephalopathy. Active physician order indicates: Low air loss mattress at all times. Comprehensive care plan indicates R111 is at high risk for developing skin breakdown related to immobility, bowel, and bladder incontinence, CVA with right sided weakness, Encephalopathy, and contracture to lower extremities. Intervention: Provide low air loss mattress at all times. 3. On 10/1/24 at 12:04PM, R104 was observed lying in bed with LAL mattress. V15 (Nursing Supervisor) lifted the linen covering R104. A flat sheet and cloth pad was observed under R104 on the mattress. R104 is wearing a disposable adult brief. V15 said that residents on LAL mattress should only have a flat sheet over the mattress, no cloth pad. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R104 is admitted on [DATE] with diagnosis listed in part but not limited to Amyotrophic lateral sclerosis, Acute and chronic respiratory failure, Tracheostomy, Dependence on respirator, Gastrostomy. Active physician order indicates Low air loss mattress in use. Check for proper functioning and setting. Comprehensive care plan indicates R104 is at high risk for pressure ulcer development or skin alteration related to decreased mobility, lateral sclerosis, respiratory failure, vent dependence, atelectasis, incontinence, and self-care deficit. Intervention: Low air loss mattress at all times. 4. On 10/1/24 at 12:10PM, R112 was observed lying in bed with LAL mattress. V15 (Nursing Supervisor) lifted the linen covering R112. A flat sheet and cloth pad was observed under R112 on the mattress. R112 is wearing a disposable adult brief. V15 said that residents on LAL mattress should only have a flat sheet over the mattress, no cloth pad. R112 is admitted on [DATE] with diagnosis listed in part but not limited to Encephalopathy, Intracranial injury, Acute and chronic respiratory failure, Tracheostomy, Dependence on respirator, Gastrostomy, Stage 4 pressure ulcer left buttocks, Type 2 Diabetes Mellitus, Morbid obesity. Active physician order indicates: Low air loss mattress in use. Check for proper functioning and settings. Comprehensive care plan indicates: R112 is at very high risk for impaired skin integrity related to chronic disease process/comorbidities, impaired mobility, and incontinence. She has pressure injury to left buttocks ischium and is at high risk for delayed wound healing and is at risk for further alteration in skin integrity. Intervention: Low air loss mattress in place with appropriate settings and functioning properly. 5. On 10/1/24 at 12:16PM, R100 was observed lying in bed with LAL mattress. V15 (Nursing Supervisor) lifted the linen covering R100. A flat sheet and folded towel was obserevd under R100 over the mattress. R100 is wearing a disposable adult brief. V15 said that residents on LAL mattress should only have a flat sheet over the mattress, no folded towel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R100 is admitted on [DATE] with diagnosis listed in part but not limited to Amyotrophic lateral sclerosis, Tracheostomy, Dependence on respirator, Gastrostomy, Stage 4 pressure ulcer sacral region, Stage 4 pressure ulcer right and left buttocks, Unstageable pressure ulcer part of back, Deep tissue damage of left upper back, right elbow, right ankle, right upper back, Unstageable pressure ulcer of left elbow. Active physician order sheet indicates Low air loss mattress in use, Check for proper functioning and settings. Wound care: Buttocks/perineum/groin cleanse with normal saline (NS), pat dry, apply zinc oxide every day shift and as needed. Left elbow cleanse with NS, betadine paint cover with foam or bordered gauze 3x/week and as needed. Left ischium cleanse with NS, keep contact layer for 3 days, change adaptic, but leave skin substitute apply alginate light pack cover with foam or bordered gauze 3x/week and as needed. Left scapula cleanse with NS, betadine paint xeroform cover with foam or bordered gauze 3x/week and as needed. Mid upper back cleanse with NS, betadine paint, xeroform cover with foam or bordered gauze 3x/week and as needed. Right buttock/ischium cleanse with NS, keep contact layer for 3 days, change adaptic, but leave skin substitute apply alginate lightly pack cover with foam or bordered gauze 3x/week and as needed. Right elbow cleanse with NS apply foam or bordered gauze 3x/week and as needed. Right lateral distal foot cleanse with NS betadine paint cover with foam or bordered gauze 3x/week and as needed. Right lateral midfoot cleanse with NS betadine paint cover with foam or bordered gauze 3x/week and as needed. Sacrum cleanse with NS keep contact layer for 3 days, change adaptic but leave skin substitute apply alginate lightly pack cover with foam or bordered gauze 3x/week and as needed. Comprehensive care plan indicates: R100 has pressure injury to sacrum, bilateral buttock/ischium, bilateral elbow, mid upper back, bilateral scapula, right flank, right lateral mid foot/distal foot and is at risk for further alteration in skin integrity. Intervention: Low air loss mattress in place with appropriate settings and functioning properly. On 10/1/24 at 1:15PM, Informed V10 (Wound Care Coordinator/WCC) of above observations with V15 (Nursing Supervisor). Requested for policy. On 10/2/24 at 2:03PM, V10 (WCC) presented policy on pressure ulcer prevention and low air loss (LAL) mattress. V10 said that they only apply a flat sheet over the LAL mattress. V10 said that they follow physician orders and implement care plan interventions. Facility's policy on Pressure Ulcer Prevention revision 1/15/18 indicates: Purpose: To prevent and treat pressure sores/injury. Guidelines: 9. Pressure reducing (foam) mattress are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc., may be used as determine clinically appropriate. Facility provided manufacture's recommendation for using low air loss mattress: 2. Cover the mattress system with a cotton sheet to avoid direct contact and reduce friction. Facility's policy on Wound Management 3/2/24 indicates: The facility will treat wounds according to physician's order and current standards of clinical practice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39781 Based on observation, interview, and record review the facility failed to monitor and supervise a resident (R154) who is identified at high risk for elopement that had eloped from the facility. The facility also failed to ensure no medications and used syringes were left at a resident's bedside. This deficiency affects all four residents (R20, R43, R53 and R154) in the sample of 30 reviewed for Residents' safety. Findings include: 1. On 10/1/24 at 11:00AM, R154 is not in his room according to resident roster given by the facility. V25 said that R154 is out on pass. R154's medical records document that R154 was admitted on [DATE] with diagnosis of Cellulitis of right lower limb, Unsteadiness on feet, Acute post hemorrhagic anemia and long-term use of antibiotics. R154 was identified as elopement /unauthorized departure risk on 9/25/24 indicated: A Evaluation: Resident have the physical ability to leave the facility; Resident verbalize anger and or a serious intent to leave the facility and has a history of unauthorized departure; Resident seek exits, pull door handles, hang around facility exits and stairways or wanders between floors; Resident becomes easily agitate, confused, and or disoriented and show poor judgement (wound not be able to safely care for him/herself outside of the facility; B. Outcome and recommendations: R154 is considered at risk for unauthorized departure/elopement/flight risk. The resident is considered at risk for unauthorized departure. Resident will be placed on elopement watch. R154's progress note entered on 10/1/24 by V25 (LPN/Licensed Practical Nurse) that R154 was out on pass at 9:13AM, then V32 (Social Service) documented that R154 was discharged to another facility at 12:13PM. V32 documented as if the resident was in the facility when discharged to another facility. R154's active physician order did not have a discharge order. There were episodes documented of R154's behavior and verbalization of leaving the facility on 9/25, 9/26 and 9/27/24. No monitoring elopement documentation found in chart. On 10/2/24 at 9:15AM, Surveyor asked V27 (Night Supervisor) What happened to R154?. V27 said that on 9/30/24 around 11:15PM, V33 (RN/Registered Nurse) reported to her that R154 is missing. They searched the 4th floor unit and other floors but were unable to find R154. V27 said that R154 was up and about and goes to other floors. R154 is alert and oriented. He uses a wheelchair within the facility, but he can ambulate. V27 said that she notified V1 (Administrator) and V2 (Director of Nursing/DON) past midnight that resident is missing and cannot be found in the facility after thoroughly searched. V27 said that she notified R154's friend of his elopement. V27 said that she called the police around 6:00AM. V27 said that R154's friend found him in a shelter home and brought him to another facility. V27 said that she did not document because she assumed V33 (RN) documented what had happened. V27 said that she did not do the incident report because the management usually does the elopement incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 9:25AM, V1 (Administrator) said that they did not do an incident report and did not report to IDPH (Illinois Department of Public Health) of R154's elopement because he was found, unharmed and was brought to another facility of his choice. V1 said that R154 was a planned discharged to this facility. V1 was informed that there is no documentation of what happened on 9/30/24 between 3:00PM to 8:00AM 10/1/24. V1 did not present any incident documentation to surveyor. On 10/2/24 at 9:28AM, V9 (Social Service Director/SSD) said that R154 has planned to discharge to another facility of his choice. R154 is not an elopement risk as indicated in his admission assessment dated [DATE]. However, he presented elopement risk behavior on 9/25/24 and was placed on the elopement risk list and care planned for elopement. V9 said that he was not aware that R154 had eloped the facility until 10/1/24 when she came to work. On 10/2/24 at 9:45AM, V15 (Nursing Supervisor) said that it was endorsed to her by V27 (Night Supervisor) that on 9/30/24 evening shift that R154 eloped from the facility. She did not know what happened to R154. On 10/2/24 at 10:00AM, During resident council meeting, R96 said that recently a resident tried to elope from the facility and was caught at the front desk. R96 did not know the name of the resident. On 10/2/24 at 10:45AM, V25 (LPN/Licensed Practical Nurse) said that she did not know that R154 had eloped from the facility. She presumed that R154 was out on pass thats why she documented it. V25 said that R154 is still active in their system and appearing on the medication administration record. R154 is alert and oriented x 2 but with periods of forgetfulness. He propels himself in wheelchair within the facility, but he can ambulate. On 10/2/24 at 10:54AM, V32 (Social Service) said that he documented the discharge notes for R154 even though he was not in the facility. V32 said that it was a planned discharged to another facility of his choice. R154 had eloped from the facility and was found by his friend in a shelter home and brought him to the facility where he supposed to be transferring. V32 said that R154 was identified as risk for elopement and care planned on 9/25/24. On 10/2/24 at 11:28AM, V34 (Primary Care Physician) of R154 said that she was not aware that R154 eloped from the facility on the evening of 9/30/24 and was transferred to another facility. V34 said that R154 is homeless and was denied by other facilities. Only this facility accepted him, and he needs medical treatment. V34 said that she would expect the facility to notify her when R154 eloped and was transferred to another facility. V34 said that she did not give an order for him to be transferred to another facility. On 10/2/24 at 11:52AM, V35 (Administrator) and V36 (Admission Director) of another facility where R154 was transferred said that R154 was dropped off by his friend to their facility. They are not aware that R154 had eloped from the facility. They called V32 (Social Service) to fax documents of R154 to their facility. On 10/2/24 at 1:29PM, V37 (Regional Director) said that they should have documentation of the elopement incident including an incident report but not necessary to report to IDPH because the resident is unharmed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 1:41PM, V2 (DON/Director of Nurses) presented an elopement incident report dated 10/1/24 at 6:54AM that she completed. V2 said that she informed V27 (Night supervisor) that she will do the incident report. V2 said that she did not notify V34 (R154's Physician) and his case manager of elopement and transfer to another facility. V2 presented R154's police report of elopement incident date 9/30/24. On 10/2/24 at 7:09PM, V38 (LPN) said that she is not aware that R154 had eloped from the facility on evening of 9/30/24. She said that R154 is alert and oriented, propels himself in wheelchair. R154 goes to other floors and stays late. V38 is not aware that he is on elopement risk. She said that R154 has 5pm and 9pm scheduled medications. She cannot recall when she gave his medication and what time she last saw him in the unit. On 10/3/24 at 9:10AM, Surveyor asked V1 (Administrator) how soon they have to document or make an incident report for a missing person. Informed V1 that R154 was noted missing on 9/30/24 at 11:15PM and no documentation was in the resident chart about the elopement incident and the elopement incident report was initiated on 10/1/24 at 6:54AM. On 10/3/24 at 11:00AM, V1 (Administrator) said that she was told by corporate that it is accepted to document at end of the shift after the task was completed. On 10/3/24 at 9:27AM, V32 (Social Service) said that R154 was placed on elopement risk on 9/25 and the interdisciplinary team was notified. V39 (Interim SSD) said that residents on elopement risk should be on monitoring every 2 hours or at least every shift it should be documented. V2 (DON) said that nursing staff monitor R154 every 2 hours, but they did not have documentation. Informed V32 that he wrote the discharge notes for R154 without physician orders of discharge to another facility. V32 did not document that R154 had eloped from the facility, went to shelter care, and was brought by R154's friend to another facility. Instead V32 charted that R154 was discharged from this facility and was transferred to another facility. V2 said that they cannot document a discharge summary if the resident is not in the facility. V2 said that nursing staff will write the discharge narrative which include resident clinical condition/status/stability, vital signs, medications and treatment instructions, personal belongings, medical equipment, transportation arrangements and discharge instructions. V2 said that discharge orders should be obtained from the primary care physician. On 10/3/24 at 10:21AM, V3 (ADON/Assistant Director of Nurses) said she is not aware that R514 is an elopement risk. V3 said that on 9/26/24, R154 displayed exiting behaviors and was observed rummaging through the dietary food cart. Resident had called 911 multiple times and stated wanting to leave the facility. V3 said that V1 (Administrator) and V2 (DON) were notified of R154 's behavior. V3 said that residents at risk for elopement should be monitored every hour to visually see the resident and document in behavior monitoring or in progress notes. V3 said that R154 did not have documentation that elopement risk monitoring was done. V3 said that on 10/1/24 when she came to work, she was notified that R154 had eloped from the facility. (continued on next page)

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	145662	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Niles	8333 West Golf Road Niles, IL 60714

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/24 at 10:36AM, V5 (Infection Control) said that he is not aware that R154 was on elopement risk. V5 said that on 9/28/24, he was called by reception staff that R154 was agitated and insisted to go out of the facility to go home. He went to see R154 and noted him to be agitated and insisted to go out of the facility to go home. V5 explained to the R154 the risk of going home without proper processess for his safety and well-being. V5 was able to convince the R154 to stay until proper discharge could be done. R154 went back up to the floor with a police officer (who according to receptionist was called by the R154). Discussed with the police officer that R154 was insisting to go home without proper and safe discharge planning. Police officer went to talk to R154. R154 was convinced to stay and follow proper process for safe discharge. V5 said that they should monitor resident every 2 hours and as needed who are at risk for elopement. V5 said that he has to check the policy but if she is the assigned nurse to R154 she will document monitoring done for R154. On 10/3/24 at 12:38PM, Informed V37 (Regional Director) of concerns above identified that there is no communication among the IDT (Interdisciplinary Team) that R154 was placed on elopement risk since 9/25/24. No documentation of elopement monitoring or supervision was done despite the risk of elopement. V34 (Physician of R154) was not notified of elopement and discharged to another facility. R154 was recently admitted to the facility due to a medical condition and needed treatment as indicated in his diagnosis and active physician order sheet. On 10/3/24 at 2:41PM, V33 (RN) said that when she made rounds on 9/30/24 around 11:15PM, she noted that R154 was not in his room. V33 said that he usually stays in the dining area on the first floor. Around 12:30AM, R154 was not yet back to his unit, she asked his 2 CNAs (Certified Nurses Assistant) to search for him. When they couldn't find him, she notified V27 11-7 Nursing supervisor. V27 notified V1 (Administrator) and V2 (DON) that R154 was missing. No code green announcement was done. They went floor to floor and asked staff to look for R154. She did not call V34 (Physician of R154). She did not document of the elopement incident; she assumed that the supervisor and DON would document. V33 said that she should have documented in R154's chart of his elopement and what they did. V33 said that she did not fill out the elopement incident report. On 10/3/24 at 8:14PM, V40 (3-11 shift supervisor) said that he is aware that R154 is at risk for elopement. V40 said that they monitor him every 2 hours but did not document it. V40 said that they should document monitoring done for R154. R154 is up and about and goes to different floors. He cannot recall when he last seen R154. He was not aware that R154 eloped from the facility on his shift. On 10/3/24 at 8:24PM, V41 (CNA) said that she is aware that R154 is risk for elopement. V41 said that they monitor him but did not document it. V41 said that she made rounds at 10:00PM, she did not see R154 in his room and in the unit. She did not report to the nurse because R41 usually goes to other floors/units and stays late at night. V4 said that she is not aware that R154 had eloped from the facility. Facility's policy on Code Green- Missing Resident/Elopement reviewed 11/15/18 indicates: Guidelines: 1. All personnel are responsible for reporting a cognitively resident attempting to leave the premises, or suspected of missing, to the charge nurse as soon as practical. This includes any resident did not sign out or did not notify a staff member of his or her leaving. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Elevate Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE: 8333 West Golf Road Niles, IL 60714	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Should an employee discover that a resident is missing from the facility, he or she should: a. Immediately report the missing resident to the charge nurse or nursing supervisor. c. Alert staff by announcing Code [NAME] over the paging system d. Inform staff of the name of the missing resident and visualize picture of resident if available e. Make a thorough search of the building premises. f. Notify the administrator and Director of Nursing immediately, if resident is not found after the search. g. The Administrator and Director of Nursing will evaluate the situation and develop a plan of action based on the individual resident. The following steps should occur: 1. A nurse should notify the attending physician. 2. Notify the resident legal representative/responsible party *Determine if friends or family knows where the resident may be attempting to go. 3. Notify the Sheriff and or police department and file a missing person report 4. Provide a search team with a resident identification information. 5. Increase search by a more extensive search of surrounding area. 6. Remain in contact with hospitals, nursing facilities, family members 7. Complete incident report and notify the state agency according to reporting guidelines. 8. Document appropriate notations in the medical record. 2. R53 was admitted on [DATE] with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus with diabetic neuropathy, Morbid obesity due to excess calories, Acute and chronic respiratory failure with hypoxia, Tracheostomy. Active physician order sheet indicates Nystatin external powder 100,000 unit/gram (Nystatin Topical) apply to skin folds, topically every 12 hours for MASD (Moisture Associated Skin Disease) abdominal and breast folds. On 10/1/24 at 11:54AM. Observed R53 lying in bed with tracheostomy connected to oxygen. Observed Nystatin powder medication container on top of her bedside tray table. V15 (Nursing Supervisor) was shown observation. The medication label read Nystatin powder 100,000 USP units/gram with R80's name. V15 said that medication should not be left at the resident bedside for safety, and medication treatment cannot be shared with another resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 1:15PM, Informed both nurses on 5th floor- V18 (RN) and V30 (LPN) of above observation. Both said, they are not aware that R80's nystatin medication was at R53's bedside tray table and they did not know how it got to R53's room because R80 is on the 2nd floor. Both said that medication should not be left at the resident bedside for safety, and medication treatment cannot be shared with another resident. On 10/3/24 at 2:30PM, Informed V2 (DON) of above concerns. V2 said that medication should not be left at the resident bedside for safety, and medication treatment cannot be shared with another resident. Facility unable to provide Medication safety policy. 49871 3. On 10/1/2024 at 11:20 AM, R20 was observed with three medications in a plastic bag on top of the bedside table. Medications include one nose drop (Fluticasone) and two eyedrops (Latanoprost, Dorzalamide). R20 said the medications belongs to her. On 10/1/2024 at 11:23 AM, V21 (Licensed Practical Nurse/LPN) said R20 has an order for those three medications and those medications should not be at bedside. V21 proceeded to take the medications with her. On 10/1/2024 at 12:13 PM, V2 (Director of Nursing/DON) said it is the expectation that no medication should be left at residents' bedside table. 50469 On 10/01/24 at 11:10 AM, observed used needle syringe on top of R43's beside counter. R43 is alert and oriented and said the nurse must have left it there. On 10/01/24 at 11:18 AM, V25 (LPN) said that used needle syringes should be disposed in a sharps container and not left at bedside. On 10/01/24 at 12:12 PM, V2 (Director of Nursing) said her expectations are not to have used needle syringes at bedside, the needle syringes should be discarded in the sharps container after use. Facility's policy on Syringe and Needle Disposal- Effective date 10/25/2014 Policy: Used syringes and needles are disposed of safely and in accordance with applicable laws and safety regulations. Procedure: B. Immediately after use, syringes and needles are placed into puncture resistant, one-way containers (sharps) specifically designed for that purpose.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation and record review the facility failed to provide a resident (R111) with a backup tracheostomy tube of appropriate size at the bedside for accidental extubation. This deficiency affects one (R111) of three residents in the sample of 30 reviewed for Respiratory care. Findings include: R111 was admitted on [DATE] with diagnosis listed in part but not limited to Acute and chronic respiratory failure with hypoxia, Tracheostomy, Gastrostomy, Anoxic brain damage. Active physician order sheet indicates Change inner cannula 6.5 size every day and night and as needed. Comprehensive care plan indicates that she has tracheostomy for impaired breathing mechanics due to acute and chronic respiratory failure with hypoxia. Interventions: Keep an additional tracheostomy tube (same size as the resident's) at bedside for an emergency situation. On 10/1/24 at 11:42AM, Rounds were made to R111 with V8 (Respiratory Therapist) and V15 (Nursing Supervisor). R111 was observed lying in bed with tracheostomy tube on room air. V8 showed surveyor the spare tracheostomy tube size of 7.5 at bedside. V8 said that R111 is on trach size 6.5. V8 said that R111 should have a trach size of 6.5 at the bedside, not 7.5. V8 said that residents with a tracheostomy should have 1 same size and 1 downsize tracheostomy tube at bedside for emergency/accidental extubation. On 10/1/24 at 1:20PM, Informed V2 (Director of Nursing) of above concern identified. Facility's policy on Accidental Extubation indicates: Purpose: A patient's airway is essential to maintain the patient's cardiopulmonary status. In case of an accidental extubation, it is absolutely necessary to re-establish an airway as quickly as possible. Policy: It is the policy of this facility to prevent accidental extubation whenever possible, however not all accidental extubation are preventable. In such instances, management of extubation will be done in a safe and effective way in accordance with applicable rules and regulations and standard of care. II. Unable to reinsert tracheostomy tube A. If unable to re-insert tracheostomy tube of original size, a tracheostomy tube of the next smaller size should be inserted. IV. Special Considerations A. A backup tube the same size or one size smaller than the prescribed size will be always kept at bedside.

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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** 39781 Based on observation, interview, and record review the facility failed to implement its medication administration policy by failing to administer treatment medication by authorized personnel and failed not to administer medication treatment supplied for one resident to another resident. This deficiency affects one (R53) of three residents reviewed for Medication administration safety. Findings include: R53 was admitted on [DATE] with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus with diabetic neuropathy, Morbid obesity due to excess calories, Acute and chronic respiratory failure with hypoxia, Tracheostomy. Active physician order sheet indicates Nystatin external powder 100,000 unit/gram (Nystatin Topical) apply to skin folds, topically every 12 hours for MASD (Moisture Associated Skin Disease) abdominal and breast folds. On 10/1/24 at 11:54AM. R53 was observed lying in bed with a tracheostomy connected oxygen. Nystatin powder medication container was seen on top of her bedside tray table. Observation was shown to V15 (Nursing Supervisor). The medication label read Nystatin powder 100,000 USP units/gram with R80's name. V15 said that medication should not be left at the resident bedside and medication treatment cannot be shared with another resident. R53 said that the CNAs (Certified Nurse Assistant) apply the nystatin powder to under her breast, abdominal folds, and groin areas. V15 said that CNAs cannot administer Nystatin medication to R53, only the nurse. On 10/1/24 at 1:15PM, Informed both nurses on 5th floor - V18 (RN/Registered Nurse) and V30 (LPN/Licensed Practical Nurse) of above observation. Both said that they did not apply the nystatin powder medication to R53. Both said, the wound care nurses are the one's administering the medication, and they are the one's documenting it in the MAR (Medication Administration Record). Both said, they were not aware that R80's nystatin medication was on R53's bedside tray table and they did not know how it got to R53's room because R80 is on the 2nd floor. Both said that medication should not be left at the resident bedside and medication treatment cannot be shared with another resident. Both said that CNAs cannot administer Nystatin medication to R53, only the nurse. On 10/1/24 at 2:00PM, Informed V2 (Director of Nursing/DON) of above observation. V2 said that medication should not be left at the resident bedside and medication treatment cannot be shared with another resident. V2 said that CNAs cannot administer medication to a resident. On 10/2/24 at 11:08AM, V16 (CNA) and V17 (CNA) said that they are administering the nystatin power medication that was at the bedside tray table of R53 to her groin, abdominal folds and under the breast as the resident requested when they were providing care to her. They did not notice that the Nystatin powder is R80's medication. They are aware that they are not allowed to administer medication, but they are just following the resident request. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 2:03PM, V10 (Wound Care Coordinator) said that they usually administered R53's nystatin medication but the nurses on the floor will document it. Informed V10 of above observation. V10 was not aware that R80's nystatin medication was at R53's bedside tray table. V10 said that medication should not be left at the resident bedside and medication treatment cannot be shared with another resident. V10 said that CNAs cannot administer Nystatin medication to R53, only the nurse. On 10/3/24 at 1:02PM, V31 (Wound Care Nurse) said he administrated R53's Nystatin powder treatment on 10/1/24 at 9AM and informed the floor nurse to document it. V31 said that he can document that he did administer the medication to R53, but it was already their practice that the floor nurse will document for them. V31 said that he used R53's Nystatin powder medication that was kept in the treatment cart. On 10/3/24 at 1:13PM, Informed V1 (Administrator) of above concerns and showed R53's Medication Administration record of Nystatin powder for September and October 2024. Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures: A. Preparation 4. Five Rights- Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. B. Administration 1. Medications are administered only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. 2. Medications are administered in accordance with written orders. 15. Medications supplied for one resident are never administered to another resident. D. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. 3. Topical medications used in treatments are listed on the Treatment Administration Record.