

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/20/2024
NAME OF PROVIDER OR SUPPLIER  Elevate Care Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Audrey Nixon Boulevard Waukegan, IL 60085	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical abuse. This applies to 1 of 8 residents (R1) reviewed for abuse in the sample of 8.</p> <p>The findings include:</p> <p>R1's physical incident report, dated 5/11/24, shows, Nursing description: (R1) wandered into another residents room and started taking the food off trays of both occupied resident. Resident was pushed by one of the occupants and fell to floor on Rt (right) side causing small laceration to rt eye brow area . R1's incident report does not show who the resident was that pushed R1.</p> <p>The facility's preliminary 24 hour incident investigation report, dated 5/11/24, shows an allegation of physical abuse with R1 and R2.</p> <p>On 5/20/24 at 9:41 AM, R1 had just got done using the restroom and was washing her hands. She had a 2 inch (approximately) scabbed over laceration on her right eyebrow. There was a faded yellow and green bruise to the right area of her eyebrow and forehead. This surveyor asked her what happened and R1 responded, A man pushed me and I fell . She also showed this surveyor a purple and yellow bruise on her right shoulder where the man pushed her. She was walking back to her bed and limping. She stated her right leg hurt from the man who pushed her.</p> <p>On 5/20/24 at 12:17 PM, V8, Housekeeper, stated she was cleaning R2's room when she saw R1 go into his room. She came out of the bathroom and heard R2 tell R1 to leave his room. R1 was backing up to leave the room when R2 came at her and pushed her down. R1 fell hard on her right side. I saw blood and started yelling help right away. R2 denied pushing R1 but V8 stated she saw him push R1 and reported that.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V8's housekeeper written statement shows, I saw the female resident (R1) come down the hall, made way for her by being in front of next room I was to get garbages. I then saw her go into the room (R2's room) and stand in front at the first male resident (R5), then she proceeded to go to their bathroom. I went in to try to ask what she needed in there but she had gotten paper towels and proceeded to get the first residents (R5) bacon. I then asked, you okay? You letting her steal your bacon? He told me it was fine and she could have it so then I went to the restroom after seeing their garbage didn't need changing and grabbed the one in restroom as soon as I got up from picking up the bag I had the bathroom door completely open, I saw the female resident (R1) backing up looking a bit scared and the 2nd male (R2) resident I guess she attempted to steal his bacon too. He was up from his chair and darting toward her a pushed her down with a lot of force and I watched her hit her head on the floor very hard. I thought I saw blood and just started yelling for help and that she had been pushed. Didn't attempt to pick her up because I didn't want to hurt her as she's very [NAME] and idk ( I don't know) she could've hurt her hip. She went down very hard. [SIC- statement is correct]</p> <p>The facility's abuse prevention and reporting, dated 12/17/21, shows, Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatments. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: .Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; .Resident to Resident Abuse (any type): A resident-to-resident altercation should be reviewed as a potential situation of abuse. Not all resident-to resident altercations result in abuse. For example, infrequent arguments or disagreements that occur during the course of normal social interactions (e.g., dinner table discussions) would not necessarily constitute abuse but should be investigated to make this determination. Resident-to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45540</p> <p>Based on interview and record review, the facility failed to assess/monitor a resident for 72 hours after having a fall and hitting their head. This applies to 1 of 3 (R4) residents in the sample of 8 reviewed for quality of care.</p> <p>The findings include:</p> <p>On 5/20/2024 at 9:36AM, R4 was observed in her room walking around with yellow/green and blue discoloration on approximately 50% or more of her forehead.</p> <p>On 5/20/2024, V2, Director of Nursing (DON), said on 5/8/2024, R4 had a fall in front of her bathroom door. V2 said R4 said she hit her head on the door. V2 said she was in charge of investigating the fall after it occurred for [R4]. V2 said vital signs and neuro checks should be done for 72 hours after a fall every shift, in the post fall occurrence charting. V2 said the post fall occurrence charting for the following 72 hours was not completed for R4.</p> <p>R4's fall report, dated 5/8/2024, states nursing supervisor was doing rounds and heard a noise come from the resident's room. R4 was seen sitting in front of her bathroom holding her forehead. Resident stated the door hit her and pointed to her forehead. R4's vitals are listed as BP 133/76, P 80, R 18, T 97.5 on 5/8/2024.</p> <p>R4's Weights and Vitals Summary, dated 3/1/2024 - 5/31/2024, shows a temperature of 97.9 degrees Fahrenheit on 5/15/2024, with no additional vitals listed after 5/8/2024 to current.</p> <p>The facility failed to provide additional post fall charting after 5/8/2024, addressing neuro checks, assessment, and vitals prior to documents dated 5/20/2024.</p> <p>The facility's Incident and Accidents - Illinois policy reviewed 4/7/2024 states . A minimum of 72 hours of documentation by all three shifts on a resident status after the incident. Vital signs, mental and physical states, follow up, tests, procedures, and findings are to be documented.</p>