

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  10/08/2024
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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541</b></p> <p>Based on interview and record review, the facility failed to have an effective process in place for staff to quickly identify a resident's code status. The facility failed to immediately provide cardiopulmonary resuscitation (CPR) to a resident (R1) found not breathing and pulseless, whose POLST (Physician Orders for Life-Sustaining Treatment) form showed the resident was a Full Code. These failures led to a delay in R1 receiving CPR and R1 dying in the facility. These failures apply to 1 of 6 residents (R1) reviewed for deaths in the facility in the sample of 6.</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on [DATE] when facility staff failed to immediately initiate CPR on R1, when he was found unresponsive and pulseless, due to facility staff not being able to quickly identify R1's code status. These failures resulted in R1 dying in the facility on [DATE]. The Immediate Jeopardy was identified on [DATE]. V1 Administrator was notified of the Immediate Jeopardy on [DATE] at 2:27 PM. This surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on [DATE]; however, noncompliance remains at a Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>The findings include:</p> <p>R1's care plan, dated [DATE], showed R1 was a cognitively impaired resident with diagnoses of dementia, cerebral infarction (stroke), dysphagia, and schizophrenia. R1 was dependent on staff for all cares. The care plan showed R1 was a Full Code and wanted full treatment/CPR in the event of a cardiac arrest. The plan showed R1 wishes for full code status, as specified in their advanced directive documents, will be honored and clearly delineated in the medical record .</p> <p>R1's POLST form, dated [DATE], showed R1 was a Full Code. Staff were to attempt CPR and provide all indicated treatments to R1 in the event of a cardiac arrest. The form was signed by V6 (R1's Physician) and R1's legal guardian.</p> <p>A physician order for R1, dated [DATE], showed R1 was a Full Code.</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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's nurses note, dated [DATE], showed R1 was found unresponsive and pulseless in his room by staff at 6:29 PM. V7, Registered Nurse (RN), started CPR on R1 and 911 was called. EMS (Emergency Medical Services) arrived at the facility at 6:35 PM and took over providing CPR to R1. R1 was pronounced dead in the facility at 7:10 PM.</p> <p>R1's death certificate, dated [DATE], showed R1's cause of death as cardiopulmonary arrest.</p> <p>On [DATE] at 9:45 AM, V5, Certified Nursing Assistant (CNA), stated she fed R1 dinner on the evening of [DATE]. V5 stated, (R1) was fine at dinner. I fed him in his room while he seated upright in his Geri Chair (reclining wheelchair). When I went back to check on him, about a half hour later, he didn't look right. He was still sitting in his chair. His eyes were open. I called out his name and he didn't respond. He didn't look at me. I didn't check to see if he was breathing. I don't know if he had a pulse. I didn't know what to do. I left the room to go find the nurse (V7, RN). I found the nurse (V7) in another resident's room and asked him to come look at (R1). (V7) walked down to (R1's) room with me. He checked for a pulse on (R1) and tried to get (R1) to respond. (V7) then walked out of (R1's) and said he had to go check to see what (R1's) code status was. (V7) went to the nurses station and checked (R1's) code status on the computer. (R7) came back into the room and started CPR on (R1) because he said (R1) was a Full Code. V5 stated she was CPR certified, but did not check R1 for a pulse or yell for help when she found R1 unresponsive because, I didn't know what to do. I was nervous. V5 stated from the time she entered R1's room and found him unresponsive, to the time V7 (RN) started CPR on R1, was probably at least a few minutes. We had to get (R1) up out of his chair to do CPR. When V5 was asked how to quickly identify a resident's code status, V5 stated, I don't know. I would have to ask the nurse.</p> <p>On [DATE] at 10:21 AM, V7, RN, stated on [DATE], he was in another resident's room when V5 (CNA) came to find him. V7 (RN) stated, (V5) asked me to come look at (R1) because she said he didn't look right. I got up and went down to (R1's) room. He was up in his wheelchair. He was not responding to me. I tried to feel for a pulse on him, but I couldn't feel one. I didn't know if he was a Full Code or not, so I went out to a computer at the nurses station to check. I saw in the computer (R1) was a Full Code. I went back in to his room and tried to feel for a pulse again. I didn't feel a pulse on (R1), so I called a code and started CPR on him. V7 stated, If I don't know a resident's code status, I have to check their medical record on the computer at the nurses station.</p> <p>On [DATE] at 9:59 AM, V6 (R1's Physician) stated, If a resident, that is a full code, is found pulseless and not breathing, staff are to start CPR on the resident immediately. V6 stated a delay in CPR could cause death. V6 stated he did not know any details surrounding R1's death in the facility, but stated, I just know he died of cardiac arrest.</p> <p>On [DATE] at 11:20 AM, V3 (Director of Nursing/DON) stated, If staff find a resident unresponsive and the resident is a Full Code, they should check for a pulse and start CPR immediately. Staff are not to leave the resident. They are supposed to shout for help. V3 stated, There really isn't a quick way to verify the code status of a resident. Staff either have to check the chart in the computer or check the DNR (do not resuscitate) lists we have located in the binders on the crash carts on the floors.</p> <p>On [DATE], V4, Licensed Practical Nurse (LPN), V8 (LPN), and V9 (LPN) each stated the only way to verify a resident's code status is by leaving the resident's room to check their electronic medical record via computers located at the nurses stations.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], V10 and V12 (CNAs) each stated they did not know how to check a resident's code status. V10 and V12 each stated they would have to ask a nurse to verify a resident's code status.</p> <p>The facility's Cardiopulmonary-CPR policy, dated [DATE], showed, The facility will provide basic life support, including CPR, when a resident requires such care, prior to arrival of EMS, subject to physician order, and resident choice indicated in the resident's advanced directives .CPR Procedure: Check for resident response while simultaneously assessing the resident for breathing and pulse for 10 seconds. Shout for help and activate the emergency response system by announcing overhead, 3 times, code blue and the location of the code .</p> <p>The facility presented an abatement plan to remove the immediacy on [DATE] at 8:08 AM. This surveyor reviewed the abatement plan and was able to accept the plan to remove the immediacy on [DATE].</p> <p>The Immediate Jeopardy that began on [DATE] was removed [DATE] when the facility took the following actions to remove the immediacy:</p> <ol style="list-style-type: none"> <li>1. R1 expired in the facility [DATE] after a code blue was initiated by staff and four rounds of epinephrine was administered by 911 EMS services.</li> <li>2. On [DATE] at 3:30 PM, Social Services Director and Director of Nursing completed full facility audit of DNR (do not resuscitate) status to ensure all POLST forms are in place and match code status in PCC (computer charting/medical records).</li> <li>3. Facility staff were educated on where resident code status is available via PCC as well as POLST binders located at each crash cart on each unit to quickly identify a resident's CPR/code status.</li> <li>4. Staff educated on facility's Code Blue Policy and process on what do to should a resident be found unresponsive and pulseless to ensure not delay in CPR including but not limited to (see attachment A):             <ol style="list-style-type: none"> <li>a. Assess for pulse and respirations</li> <li>b. Verify code status/advanced directives</li> <li>c. If a resident is a Full Code, announce Code Blue via overhead paging-give specific location</li> <li>d. Licensed nurses and other staff will respond</li> <li>e. Call 911</li> <li>f. CPR started by first person on scene. CPR will be alternated between the nursing staff until the ambulance arrives.</li> </ol> </li> <li>5. Education on Code Blue policy and POLST binders location on each crash cart to quickly identify code status has been included in facility new hire orientation process and annually for all staff.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. Based on facility staffing roster as of [DATE] at 11:00 PM, education has been provided to all RNs, LPNs, and CNAs staff currently present in the facility and all staff not present in the facility, have been in-serviced over the phone and will be re-serviced before the start of their next shift.</p> <p>7. Emergency QA meeting conducted on [DATE] at 7:35 PM with facility Medical Director.</p> <p>8. The Director Of Nursing/DON will conduct random audits of 5 staff members, 4 times a week for 3 months, to ensure staff is able to state facility's Code Blue Policy, how to quickly identify a resident's code status, and immediately initiate CPR as/when indicated.</p> <p>9. The DON will conduct random audits of 5 staff members, 4 times a week for 3 months, to ensure they are aware of the POLST binders located on each crash cart in the facility for quick identification of code status.</p> <p>10. Social Services will conduct audits of POLST binders, 2 times a week for 3 months, to ensure the binders are up to date with the latest POLST information.</p>		