

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 11/15/2024
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 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate hand and nail care to 1 of 3 (R1) dependent residents with a hand contracture who were reviewed for improper nursing care; failed to follow facility policies for nail care, morning/nighttime care, and for bed baths. This failure resulted in R1 having a foul odor to her left hand and obtaining an open wound to the palm of her contracted hand that required immediate treatment by the facility's wound care team.</p> <p>Findings include:</p> <p>Review of R1's medical record showed she admitted to the facility on [DATE], and has a past medical history not limited to: encephalopathy, traumatic subdural hemorrhage, acute respiratory failure, obesity, and fractures to base of skull, nasal bones, and multiple cervical vertebrae.</p> <p>Review of R1's restorative observation, dated 08/19/2024, documented she is dependent on staff assist for activities of daily living (ADL'S), transfers, and mobility, and is total hands on assist to keep clean and dry with bowel and bladder. Range of motion services were offered and refused, noted with facial grimacing and shaking her head no.</p> <p>Review of R1's Minimum Data Set (MDS) Section C for Cognitive Patterns, dated 08/21/2024, showed Brief Interview for Mental Status (BIMS) score of 99, indicating interview could not be conducted due to cognitive impairment. MDS Section GG for functional abilities and goals, dated 08/21/2024, showed she was dependent of two or more staff for showers/bathing and personal hygiene.</p> <p>Review of R1's care plan documented she would benefit from an active assistive range of motion program because she is at risk for developing contractures/has actual contractures related to physical inactivity with date initiated of 11/14/2024; has the potential for/a cognitive problem related to BIMS score, staff assessment, difficulty making decisions, head injury, impaired decision making, and encephalopathy with date initiated of 08/27/2024; Resident is at risk for alteration in skin integrity related to: Anemia, Braden Scale Score, Impaired mobility, Incontinence of Bowel, Incontinence of Urine, Malnutrition, Medical Devices (c-collar, gastrostomy), Pneumonia, fractures, dysphagia, subdural hemorrhage, encephalopathy, respiratory failure, fractures, on anticoagulants with date initiated of 07/17/2024 and an intervention to monitor skin during care and report any changes.</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 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/14/2024 at 11:43 AM, V3 (Licensed Practical Nurse) said grooming and nail trimming is done by the aides, mainly on their shower days. She added the aides are to complete a shower skin that documents type of bath given, added cares provided, and if there was any skin redness or open areas, they should be communicated to the nurse. V3 then said if a resident has a contracted hand, then the hand should be washed daily, and any issues or concerns should be communicated to the nurse.</p> <p>On 11/14/2024 at 11:53 AM, R1 was awake and lying in bed. R1 was non-verbal. Noted a foul odor within the room and near her bed. R1 was moving and turning her arms /hands around, and surveyor observed contractures to both hands, with all her fingers touching the palm. The length of R1's fingernails to both hands extended approximately 5-6 millimeters in length past the tip of her fingers. Beneath R1's middle finger was what appeared to be a small piece of dry and discolored skin flap that was visibly protruding from beneath the tip of her finger. A moderate amount of light brown colored build-up that was foul smelling covered the lateral side of R1's index finger and along the medial aspect of the thumb to her left hand.</p> <p>On 11/14/2024 at 11:56 AM, V4 (Licensed Practical Nurse/LPN) assessed R1's hands. V4 said resident fingernails are normally trimmed on their shower days and R1's nails should not be the length that they were, then said it looked like the nail is digging into her skin that has caused an injury to her hand. V4 (LPN) then said hand care should be done daily to a contracted hand, and said she has not provided hand care to either of R1's contracted hands. V4 indicated there was a foul odor present to R1's left hand. At 12:02 PM, V4 showed surveyor completed shower/bath sheets dated from November 1st through the 12th for the third floor shower book, with no shower/bath sheet found for R1. V4 said there should be shower/bath sheets for R1 during that timeframe. Review of shower skin notification sheet showed options for shower, bed bath, or refused, and listed care areas to be addressed for hair, face, torso, oral care, feet, legs, shave, fingernails, peri area, buttocks and under breasts. Form also provided area to document skin characteristics, and aide/nurse signatures.</p> <p>On 11/14/2024 at 12:07 PM, V5 (Certified Nursing Assistant/CNA) said she gave R1 a bed bath before breakfast. V5 added she washed R1's upper body and private areas, but did not attempt to wash R1's hands today because she usually flinches in pain then pulls her hands away. At 12:44 PM, V7 (CNA) working on first floor said hand care should be provided daily with a contracture, and she usually trims a resident's fingernails weekly if needed.</p> <p>On 11/14/2024 at 12:51 PM, V2 (Director of Nursing/DON) said on a resident's shower or bed bath day, the aides are to complete a bathing sheet and document electronically, then report any issues to the nurse who is to assess the resident. V2 added when completing a shower skin sheet, all areas on the form must be addressed to ensure that all residents received their scheduled shower or bed bath, and what additional care was provided to the resident. V2 said if a resident has a contracture, hand/nail care is provided during their scheduled shower or bed bath, and fingernails should be trimmed per patient preference if verbal, and trimmed weekly or biweekly depending on the length if non-verbal. V2 also said he believed the facility protocol is to place a towel or foam hand roll to a contracted hand when there is not an order for a hand splint to prevent skin breakdown. At 1:45 PM, V2 said R1 was found to have long fingernails and a cut to the palm of her left hand, which the treatment team is preparing to assess.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/14/2024 at 1:51 PM, V8 (Wound Nurse) stood in the doorway of R1's room and in front of a treatment cart. A foul odor was present at the doorway of R1's room. V8 said he had just washed R1's hand and trimmed the fingernails to both of her hands. V8 added the foul odor came from washing the build-up of sweat and debris trapped within the skin folds of R1's contracted hand. V8 said he trimmed R1's fingernail because a nail was digging into her left hand that caused a cut to her palm.</p> <p>On 11/14/2024 at 1:53 PM, V9 (Nurse Practitioner) assessed R1 left hand. V9 said R1 sustained an open wound to the palm of her left hand, caused by her long and sharp fingernail. Surveyor observed an actively bleeding open wound to the R1's left palm that measured in centimeters (cm) approximately 1.00 x 1.00 (length x width). V9 added she will order a topical triple antibiotic ointment and the placement of a hand roll to R1's contracted hands. V9 also said R1 had not recently received hand care, and was previously placed on the monthly podiatrist list.</p> <p>Review of Wound Assessment Details Report, with assessment time and date of 11/14/2024 at 2:29 PM, documented the following: Facility-acquired, traumatic abrasion identified on 11/14/2024 that measures 1.00 x 1.00 x 0.10 (L x W x D) in centimeters. Last Braden Score of 12 (High Risk) dated 10/14/2024 indicated R1 is at high risk of developing pressure ulcers.</p> <p>Review of Nurse Practitioner Progress Notes, with effective time and date of 11/14/2024 at 2:44 PM (14:44), documented the following: Per nurse, patient has a wound on her left palm, as her contracted fingers are always in contact with that aspect of her hand. Patient examined in her room with wound registered nurses. She has a shallow puncture wound, just right up to the first layer of the epidermis, at the stratum granulosum, to be exact, measuring less than 1cm in diameter, circular shape, new from either today or yesterday, as the visible stratum granulosum appears very fresh. Wound registered nurse trimmed her nails, as podiatry hasn't been by. She has a standing order for podiatry consult. Wound cleaned, and applied with topical antimicrobial agent, and covered with gauze to prevent further abrasion of the wound bed. Temporary grip rolls are applied to both hands. Will update restorative nursing.</p> <p>On 11/14/2024 at 2:52 PM, V10 (Restorative Director) said R1 was added to restorative today for range of motion because she was not previously on a program, due to noted pain when assessing her hands.</p> <p>Review of R1's Order Summary Report for Active Orders, dated 11/15/2024, showed the following: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete Nursing Skin Assessment Form every day and evening shift every Tuesday, Thursday, Saturday for Weekly Showers/Skin Assessment with a start date of 07/18/2024; Bacitracin Ointment 500 UNIT/GRAM-apply to left hand topically every day shift and as needed for wound care. Cleanse with normal saline prior to application. Pat to dry. Cover/top with rolled gauze/kerlix with order date or 11/14/2024.</p> <p>On 11/14/2024, requested from V2 (DON) R1's shower sheets for the last thirty days, podiatry notes for the last three months, and R1's aide bath charting for the last thirty days. None were provided.</p> <p>Review of Nail Care policy, last revised 01/25/2018, documented to observe condition of resident nails during each time of bathing. Note cleanliness, length, uneven edges, hypertrophied nails.</p> <p>Review of Morning Care (A.M. Care) policy, last revised 01/31/2018, reads:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Purpose: To promote comfort, cleanliness and dignity.</p> <p>Guidelines: Explain procedure to resident and bring equipment to bedside or to bathroom. Provide privacy. Prepare water to wash, offer washcloth to wash hands. Allow/assist resident with cleansing body, face, hands, arms, underarms and perineum. Observe for skin problems. Report any abnormal findings such as bruising, reddened areas or breakdown. Document care and assistance provided in electronic record.</p> <p>Review of Bedtime Care (HS Care)) policy, last revised 01/24/2018, reads:</p> <p>Purpose: To promote comfort and relaxation before sleep.</p> <p>Guidelines: Offer washcloth to wash hands and face, assist as needed. Document care and assistance provided.</p> <p>Review of Complete Bed Bath policy, last revised 01/31/2018, reads:</p> <p>Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity.</p> <p>Guidelines: A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or requested.</p> <p>Procedure: Explain procedure, provide privacy. Drape resident to maintain dignity by not exposing body and to keep resident warm. Place towel under far arm. Wash, rinse and pat dry hand, arm, shoulder and underarm. Repeat for the other arm. Call for nurse to report any reddened areas, skin discoloration or breakdown. Document bathing task and assistance provided in the electronic record.</p>