

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  01/15/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</b></p> <p>Based on observation, interview, and record review, the facility failed to assess and approve a resident to self-administer medications, which applies to 1 of 3 residents (R116) reviewed for self-administration of medication in a sample of 32.</p> <p>The findings include:</p> <p>R116's Facesheet, printed on 1/15/25, showed R116 to be a [AGE] year old male admitted to the facility with diagnoses which include: chronic respiratory failure with hypercapnia/hypoxia, tracheotomy, and chronic obstructive pulmonary disease.</p> <p>On 1/14/25 at 12:45 PM, R116 started a nebulizer treatment in his room by himself. R116 stated the respiratory therapist (V6-Respiratory Therapy Manager) brought him the stuff (ampule of medication), and R116 started the treatment himself.</p> <p>On 1/14/25 at 2:00 PM, V2, Director of Nursing, stated for a resident to be able to self-administer medications, they need to be assessed and have a physician order to make sure they can take a medication correctly. This applies to all types of medications (pills, inhalers, nebulizer treatments).</p> <p>On 1/14/25 at 2:30 PM, V6 (Respiratory Therapy Manager) stated she does give R116 his nebulizer medication ampule, and R116 starts it after he does his deep breathing and coughing. V6 stated she listens to the resident's lung sounds, gives him the medication, and rounds back after 5-10 minutes to listen afterwards. V6 stated R116 is the only resident doing their own breathing treatments at this time. V6 stated she did not know a resident needed an assessment and physician order to self-administer medications.</p> <p>R116's Order Summary Report, printed 1/15/25, showed no order to self-administer nebulizer treatments prior to 1/14/25.</p> <p>R116's Medical Record had no assessment for self-administration of medications as of 1/14/25.</p> <p>R116's current Careplan (received 1/15/25) showed no focus area of self-administration of medications.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's undated Self-Administration of Medications Policy showed residents who request to self-administer drugs will be assessed using the Self Administration tool. The assessment results will be discussed with the attending physician and an order will be obtained from the physician if appropriate.</p>

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>40085</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from resident to resident physical and verbal abuse. This applies to 1 of 32 residents (R84) reviewed for abuse in the sample of 32.</p> <p>The findings include:</p> <p>A facility provided Final Incident Investigation report, completed on 11/7/24 by V1 (Administrator), shows on 11/1/24, there was a physical altercation between R84 and R166. Both residents are described as being alert and oriented with no cognitive impairments. The report documents R84 had gone to R166's room to discuss something with him and they had a verbal disagreement, which escalated to R84 being knocked out of her chair onto the floor. The report documents V15 (CNA/ Certified Nursing Assistant) had witnessed the incident and intervened removing R84 from R166's room.</p> <p>R84's 11/1/24 nursing progress note completed by V16 (Assistant Director of Nursing/ADON) shows R84 refused to have a full body assessment done after the incident, but she reported she was having pain to her left lower extremity and right arm.</p> <p>On 1/15/25 at 11:43 AM, V14 (Social Services) said she was involved immediately after the incident between R84 and R166. V14 said R84 and R166 have become a couple at the facility. R84 came to her and told her R166 had gotten upset with her while she was in his room, and he tipped her wheelchair over and she fell on to the floor. V14 said R84 wanted to press charges against R166, so she called the police and they came to the facility and R166 was taken into custody. V14 said R84 was crying and upset and said her pride was hurt. V14 said she had went and spoken with R166, who denied pushing R84 out of her wheelchair.</p> <p>On 1/15/25 at 11:48 AM, V15 (CNA) said he was at the computer that morning on 11/1/24 to log in, and he heard someone yelling help and went to R166's room and found R166 standing over R84. R84 was lying on the floor and her wheelchair was tipped over. R166 had his fists out ready to hit R84. V15 said got in between them to stop the incident. V15 said R166 was going to hit her for sure had he not jumped in between. V15 said R84 told him R166 had knocked her out of her wheelchair, so he helped get R84 up and out of R166's room. V15 said R84 told him her pride was hurt, and R166 was saying get that F***** B**** out of here. V15 said R84 was removed from the unit, and R166 was arrested shortly after the incident.</p> <p>On 1/15/25 at 12:09 PM, V16 (Assistant Director of Nursing/ADON) said she did a body check/ skin assessment on R84 after the incident between R84 and R166 and found no skin alterations or signs of injury. R84 reported she had pain at a 6/10 to her left lower extremity and 3/10 on the right deltoid. R84 refused any X-rays, or diagnostic tests to be done. V16 said R84 and R166 are in a relationship on the unit and both residents are alert and oriented x 3. V16 said R84 told her R166 had pushed her over in her wheelchair.</p> <p>(continued on next page)</p>		

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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>On 1/15/25 at 1:07 PM, V17 (Registered Nurse/ RN) said she was getting off shift on 11/1/24, and heard a resident yelling get out of my room it; was R166 so she sent V15 to check what was going on. V15 brought R84 out of the room and he said R84 was on the floor. V15 said she tried to assess R84 who refused saying she was fine and I am gonna get him, he messed with the wrong person.</p> <p>On 1/15/25 at 1:19 PM, V1 (Administrator) said she investigated the incident between R84 and R166 and substantiated abuse. V1 said R84 reported to her R166 had flipped her chair over and she fell on to the floor. V1 said V15 had informed her of R166 having a clenched fist directed towards R84, but he did not hit her. V1 said R84 went to V14 after the incident wanting to press charges against R166, so the police were called and came to the facility and took R166 into custody for assault and battery. V1 said R166 was also found to have a prior warrant for his arrest, so he remained at a local jail. V1 said R84 was also granted an order of protection against R166 so he was not allowed to return to the facility. V1 said R166 contacted her to pick up his belongings and told her it was his own fault, and he should not have done what he did.</p> <p>R84 was attempted to be interviewed by this surveyor on 1/13/25 again on 1/15/25, and she became agitated and waved her hand toward the surveyor saying, I have nothing to say to you, I am fine.</p> <p>The facility provided Abuse Prevention and Reporting policy, last revised on 10/24/22, shows that residents should be free from abuse. Abuse is defined as physical, sexual, mental or verbal abuse. Physical abuse is the infliction of injury which may include hitting, slapping, pinching, kicking, and controlling behavior. Verbal abuse is defined as mocking, insulting, ridiculing, yelling and can also be considered mental abuse.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085</b></p> <p>Based on interview and record review, the facility failed to follow its abuse policy for 1 of 6 residents (R166) reviewed for abuse policy and procedures in the sample of 10.</p> <p>The findings include:</p> <p>R166's face sheet shows he was admitted to the facility on [DATE], and is a [AGE] year old white male.</p> <p>R166's criminal history background check shows it was initiated on 5/28/24, however, R166's race was listed as black on the report, and it shows the results listed as IN PROCESS. A second Criminal History Report, dated 6/27/24, shows R166 has a HIT and has had prior arrests, which included domestic battery. A copy of R166's fingerprint search and risk analysis report was requested and not provided by the facility.</p> <p>On 1/15/25 at 2:08 PM, V1 (Administrator) and V9 (Assistant Administrator) said there was a mix up and corporate had not forwarded the results of R166's Criminal History Report that showed R166 had a HIT, so fingerprints were never ordered for R166. V1 said she was not aware of R166 having a HIT on his background checks until after an incident on 11/1/24, when R166 had a physical altercation with another resident (R84). V9 said the process should be the admission department runs the initial criminal history, and if a HIT is identified, then the request for fingerprints is sent immediately.</p> <p>On 1/15/25 at 2:35 PM, V28 (Admissions) said R166 was admitted on [DATE], and she submitted for the criminal history record that same day, but she had listed his race as black which was not accurate, so when she saw he was white, she resubmitted a new background request, and it was listed as held since she was making a change. V28 said she was off work when the final background check came back and showed he had a HIT, so nothing was forwarded on for fingerprints to be done. V28 said what should have happened then, was Social Services should have been notified so fingerprinting could be done immediately, but that did not happen. V28 said the facility did not know R166 had a HIT until after the incident on 11/1/24.</p> <p>The facility provided abuse policy shows the facility will take the following measures to protect residents from abuse, request background checks within 24 hours after the resident is admitted and while awaiting fingerprints to be obtained the facility will take all steps to ensure the safety of the residents at the facility.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>33760</p> <p>Based on observation, interview, and record review, the facility failed to provide meaningful activities to dementia residents to 2 of 32 residents (R70, R111) reviewed for activities in the sample of 32.</p> <p>The findings include:</p> <p>1. R70's activity careplan, dated 12/2/24, showed, (R70) is a part of the AOW (activity on wheels) program. (R70) has a pleasant demeanor and is an active participant in both group activities and independent activities. She enjoys playing bingo, puzzles, brain games, and doing arts and crafts .</p> <p>On 1/13/25 at 10:36 AM, R70 was in bed. R70 said there was nothing to do, it gets boring. All we do in our room is to stare at each other. At 11:00 AM, 1:00 PM, and 2:00 PM, R70 remained in bed. No noted activities were offered.</p> <p>On 1/14/25, at 10:00 AM, R70 was sitting in her wheelchair. An overhead announcement of, Music activity on 2nd floor. When asked if she wanted to go to the Music Activity, R70 said she does not want music. At 11:00 AM, R70 was in bed.</p> <p>On 1/14/25 at 11:06 AM, V8 (Activity Assistant) said she offered R70 juice yesterday from the AOW. V8 said today she offered her to go to the music activity, but she refused. When asked if V8 was aware of R70's activity preferences (puzzles, brain games), V8 said No.</p> <p>R70's 1:1 visit form, dated January 2025, marked ta with code taste.</p> <p>2. On 1/13/25 10:40 AM, R111 was in bed with her doll. At 1:00 PM, R111 was in her wheelchair by the nurses station attempting to get up from her chair numerous times. Staff repeatedly told R111 to sit down. Staff also put R111's doll in her lap, which R111 then put by her side, and attempted to get up multiple times. At 2:00 PM, R111 was still in her wheelchair being redirected to sit down; no activities being offered.</p> <p>R111's careplan dated 1/6/25 showed, (R111) is a AOW resident that likes to sit up in her chair in the hallway, watch movies and TV shows in her room. She also benefits in accepting AOW materials such coloring pages, sensory items, snacks, and books</p> <p>On 1/14/25 at 11:10 AM, V8 said she had to go home yesterday and did not get to see R111. V8 said most of the time R111 was in bed asleep.</p> <p>R111's 1:1 visit form, dated January 2025, was marked, asleep.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/15/25 at 9:18 AM, V9 (Assistant Administrator) and V10 (Activity Director) both said they were in process of increasing Activity staffing in the 4th floor dementia unit. (R70) is higher functioning and will be provided brain games. (R111) needed to be provided with sensory activities to keep her busy. The sensory items were kept in the Social Services Director's office who was unavailable this week. Activities are important especially in the Dementia Unit, it gives the residents something to do and enhances their well being.</p> <p>The facility policy on Activity Program, dated 11/2000, show, The facility shall provide ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>37232</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion (ROM) was evaluated for a brace and received ROM exercises for 1 of 4 residents (R63) reviewed for ROM in the sample of 32.</p> <p>The findings include:</p> <p>R63's Care Plan, with an initiated date of 10/12/22, showed R63 would benefit from an active assisted ROM program 3-7 days a week.</p> <p>R63's Order Summary Report, dated 1/15/25, showed an order for restorative nursing to evaluate R63's left wrist/finger contractures for the use of a splint or any other support to prevent further contractures. The order was dated 11/26/24.</p> <p>R63's Progress Note entered by a Nurse Practitioner, dated 11/26/24, showed restorative advised to evaluate resident for possible use of a splint or other appropriate device to prevent further contractures of the left wrist and finger.</p> <p>On 1/14/25 at 11:20 AM, R63 was in bed. R63's left wrist was bent/contracted in the flexed position at about 90 degrees. R63's left index finger was straight. R63 was asked if he can move his left wrist and index finger, and R63 was not able to move them. R63 said he asked a doctor for a brace over a month ago. According to R63, the doctor said they would put an order for a brace. R63 said he did not routinely receive ROM exercises for his left wrist/finger.</p> <p>On 1/14/25 at 11:37 AM, V5 (Restorative Nurse) said when a resident needs to be evaluated, restorative tries to see a resident as soon as possible and the latest being one week. V5 said she was not aware of the order for restorative to evaluate R63 written on 11/26/24, and R63 had not been evaluated for a possible splint. V5 said normally therapy would evaluate a resident for a splint, and the last time therapy saw R63 was on 10/22/24. V5 said R63 was receiving ROM (Range of Motion).</p> <p>R63's Task documentation for Restore: Range of Motion from 12/16/24-1/13/25 (30-day look back period) showed R63 did not receive ROM 3-7 days a week on the weeks of: 12/16/24, 12/22/24, and 1/5/25 (3 out of 4 weeks). There was no documentation on the ROM Task on the following dates: 12/17/24, 12/18/24, 12/20/24, 12/26/24, 12/27/24, 12/28/24, 1/4/25, 1/9/25, and 1/12/25. Not applicable was documented on the following dates: 12/19/24, 12/23/24, 12/24/24, 12/25/24, 12/30/24, 1/2/25, 1/6/25, 1/7/25, and 1/8/25.</p> <p>On 1/14/25 at 11:37 AM, V5 said when not applicable is documented that means the ROM was not done.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>33760</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident (R112) receiving tube feedings had their weight monitored. This failure resulted in R112 sustaining a significant weight loss. This applies to 1 of 6 residents (R112) reviewed for weight loss in the sample of 32.</p> <p>The findings include.</p> <p>R112's Physician Order Sheet (POS), printed on 1/14/25, showed R112 has diagnoses that include difficulty swallowing due to stroke, and gastrostomy. The same POS showed R112 has an order of tube feedings with Glucerna 1.5 at 60 milliliters (ml) per/hour x 10 hours (on at 8PM off 6AM) date of order 11/4/24. R112 was also on general diet mechanical soft with nectar thick fluids.</p> <p>R112's Progress notes by V13 (Dietitian), dated 11/4/24, recommends reinstate Glucerna 1.5 run x 75 ml/hr x hours .Monitor weight x 4 more weeks . No weekly weights were done in November 2024.</p> <p>R112's progress notes, dated 12/22/24, by V12 (another facility Dietitian) showed, Dec (December) weight pending. Nov (November) weight 173 lbs .General diet mechanical soft texture. TF (Tube feeding Glucerna 1.5 60 ml/hour x 10 hours (on 8PM of 6AM) .continue with present management pending present weight. Please weigh resident.</p> <p>R112's progress notes, dated 1/2/25, by V12 (another facility Dietitian) showed Dec weight pending. Nov weight 173# (pounds). General diet mechanical soft texture. TF (Tube feeding Glucerna 1.5 60 ml/hour x 10 hours (on 8PM of 6AM) .continue with present management pending present weight. Please weigh resident.</p> <p>R112's careplan, dated 1/2/25, shows, Requires enteral feedings as a supplement to oral feeding that puts resident at risk for: Aspiration, Malnutrition, Dehydration, and Intolerance.</p> <p>R112's Weights and Vitals Summary printed on 1/14/25 showed weights of:</p> <p>January 6, 2025 -156.6 pounds (lbs).</p> <p>December 2024 - No weights.</p> <p>November 16, 2024 -173 lbs.</p> <p>A weight loss of 17 lbs or 9.36% weight loss (from November 2024 and January 2025 weight.)</p> <p>On 1/13/25 at 12:30 PM, R112 was being fed lunch. V7 (Registered Nurse) said R112's food intake varies. R112 was also on tube feeding.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40085</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were supervised during medication administration for 2 of 32 residents (R16, R42) reviewed for pharmacy services in the sample of 32.</p> <p>The findings include:</p> <p>1. On 1/13/25 at 10:35 AM, on R16's bedside stand was a small orange pill. R16 was asked what the medication was and he responded it was Adderall from his morning medication he did not take because he didn't want to stimulate his system more. R16 said his nurse (V20) had brought his pills in that morning.</p> <p>R16's Physician Order Summary (POS) shows he has an active order for Adderall 20 milligrams (mg.) to be given two times a day. R16's POS does not show an order to self-administer oral medications.</p> <p>On 1/13/25 at 11:46 AM, V20 (Registered Nurse/RN) said no residents on the unit can self-administer their own oral medications (pills); nurses have to watch the residents take their medication. V20 said she had taken in R16's medication that morning, and she had thought he had taken the medication.</p> <p>2. On 1/14/25 at 10:10 AM, R42 had 2 plastic medication cups with approximately 18 medications inside them. R42 said they have been leaving her medication with her to take for a long time because she needs to eat food with her medication.</p> <p>On 1/14/25 at 2:00 PM, V2 (Director of Nursing) said no residents have orders for oral pills/medications to be left at the bedside to take on their own. V2 said nurses have to stay and watch residents take their medications.</p> <p>R42's POS does not show an order for her to self-administer oral medications. R2's Medication Administration Summary shows on 1/14/25 at 9:00 AM, she was scheduled to receive 16 pills during morning medication pass.</p> <p>The facility provided Medication Administration policy (undated) shows that residents can only self-administer medications with a physician order, and that nurses should supervise residents after ingesting the medication to ensure they ingest it all.</p>		

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  01/15/2025
NAME OF PROVIDER OR SUPPLIER  Elevate Care Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE  2222 Audrey Nixon Boulevard Waukegan, IL 60085	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>45540</p> <p>Based on observation and interview, the facility failed to ensure food was palatable for resident consumption. This applies to 4 of 32 (R71, R38, R103, R34) residents in the sample of 32.</p> <p>The findings include:</p> <p>On 1/13/2025 at 1:33PM, the cooked chicken for the lunch service was on the steam table waiting to be served. However, staff had to reheat the chicken in the oven prior to plating.</p> <p>On 1/13/2025 at 1:11PM, R71 stated the chicken was very hard and it was tough. R71 said she couldn't eat it.</p> <p>On 1/13/2025 at 1:10PM, R38 said his chicken was very dry and only ate half of the breast.</p> <p>On 1/13/2025 at 1:08PM, R103 said his chicken was a tiny drumstick and a wing and tasted overdone.</p> <p>On 1/13/2025 at 10:35AM, R34 said, The food; it is terrible here.</p> <p>On 1/13/2025 at 1:23PM, the facility provided a test tray to surveyors, which included chicken, carrots, mashed potatoes, and cornbread. The chicken on the test tray provided appeared dry and overcooked. Upon tasting the chicken on the lunch tray, it tasted dry and the texture was tough.</p> <p>On 1/15/2025 at 9:04AM, V26, Assistant Food Service Manager, said the food shouldn't be hard or dry. V26 said chicken breast or tenderloin should be juicy on the inside and not dry.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37232</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff used the required personal protective equipment (PPE) when entering a contact isolation room, and failed to have signs up identifying residents on isolation for COVID-19. This applies to 3 of 32 residents (R78, R54, and R148) reviewed for infection control in the sample of 32.</p> <p>The findings include:</p> <p>1. On 1/13/25 at 9:52 AM, there was a sign on the door frame of R78's room indicating R78 was on contact isolation.</p> <p>On 1/13/25 at 9:54 AM, V3 (Certified Nursing Assistant - CNA) entered R78's room. V3, without having gloves or a gown on, repositioned R78 in bed, rearranged R78's pillow that was under R78's head, and adjusted the blankets R78 was using.</p> <p>On 1/14/25 at 1:21 PM, V23 (CNA) said gowns and gloves are the required PPE that staff are to put on before entering a contact isolation room.</p> <p>R78's Care Plan, printed on 1/14/25, showed R78 was on isolation for extended-spectrum beta-lactamases (ESBL) of the urine.</p> <p>R78's Medication Administration Record for January 2024 showed R78 was being treated with an antibiotic for ESBL. The last dose was given on 1/13/25 at 2:00 PM.</p> <p>The facility's Contact Precautions policy (undated) showed the purpose was to prevent the spread of infection within the facility through the use of contact precautions. The same policy showed gown and gloves should be worn when entering a contact isolation room.</p> <p>40085</p> <p>2. On 1/14/25 at 10:07 AM, V21 (Licensed Practical Nurse/LPN) was outside the doorway to R148's room with her medication cart. There was no signage identifying R148 was on isolation, and there was no personal protective equipment (PPE) bin outside the room. The surveyor entered R148's room, and R148 said to the surveyor she is trapped in the room because she tested positive for Covid. The surveyor exited the room and confirmed with V21 that R148 had tested positive for Covid on 1/10/25, and isolation signs should have been hung outside of her door to alert staff and visitors that PPE is required to enter her room. V21 said gowns, gloves, and N95 masks are required to enter the room of all residents positive for Covid.</p> <p>On 10/14/25 at 10:13 AM, V21 confirmed R54 also tested positive for Covid on 1/10/25, and she had no isolation signs or PPE outside of her door.</p> <p>R148 and R54's Covid results and nursing progress notes both confirm they tested positive for Covid on 1/10/25 and were on contact and droplet isolation precautions.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Elevate Care Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE  2222 Audrey Nixon Boulevard Waukegan, IL 60085	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25 at 11:11 AM, V24 (Infection Preventionist) confirmed R148 and R54 both tested positive for Covid on 1/10/25, and she said contact droplet isolation signs should have been hung on the outside of their doorways that day after their room changes, but the signs did not get moved.</p> <p>The facility provided Clinical Care Practice Infection Prevention Manual (undated) shows residents who test positive for Covid should be placed on isolation with signage and PPE outside the residents door.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45540</p> <p>Based on interview and record review, the facility failed to assess a resident over [AGE] years of age for their pneumonia vaccination and failed to assess a resident for the influenza vaccination. This applies to 3 of 5 (R27, R23, R17) residents reviewed for vaccinations in the sample of 32.</p> <p>The findings include:</p> <p>R27's Clinical - Immunizations document, dated 1/15/2025, lists the resident as [AGE] years of age with an influenza administration date of 1/14/2025.</p> <p>R23's Clinical - Immunizations document, dated 1/15/2025, lists the resident as [AGE] years of age with an Pevnar 13 dose administered on 4/21/2024.</p> <p>R17's Clinical - Immunizations document, dated 1/15/2025, lists the resident as [AGE] years of age with a Pneumovax Dose 1 administered on 6/17/2018.</p> <p>On 1/15/2025 at 10:34AM, V24 Infection Control Preventionist (ICP) Nurse stated R27's influenza vaccine should have been offered at the start of flu season. V24 said she tried to reach out to R27's Power of Attorney (POA) and was unable to get a hold of them. V24 said she does not have a record showing attempted communication with R27's POA. V24 said R23 should have received another pneumonia vaccine dose by now. V24 said she is unsure what pneumonia vaccination R17 received in 2018, and should have followed up to see which dosage was administered. V24 said residents are screened upon admission for vaccination status and their vaccination status should be followed up on.</p> <p>The facility provided Influenza and Pneumococcal Immunizations, revised 4/21/2022, states, On admission, each resident or the resident's representative will be provided education regarding the benefits and potential side effects of the immunization. Once a consent is signed indicating that they wish to receive the influenza vaccine, this consent is valid for the duration of the resident's stay and the influenza vaccine will automatically be given annually. each resident is offered an influenza immunization October 1 through March 31 annually. each resident is offered a pneumococcal immunization per CDC recommendations. unless the immunization is medically contraindicated or the resident has already been immunized.</p>		