STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to perform dressing changes and daily assessments of a wound as ordered for two days, and failed to address a foul odor in the sacral wound for six days. This affected one of three residents (R6) reviewed for pressure sore prevention and treatment. This failure resulted in an abscess/infection forming behind the sacral wound that needed to be surgically drained while hospitalized , and the sacral wound developing a foul odor which was not identified at the facility. Findings Include: R6 is an [AGE] year old with the following diagnosis: urinary tract infection, peripheral vascular disease, hemiplegia of the left and right side following a cerebral infarction, and chronic ischemic heart disease. The Care Plan that is not dated documents R6 has a pressure ulcer at the sacrum that is unstageable related to deconditioned status, impaired mobility, friction/shear risk, and incontinence. Interventions include: evaluate ulcer characteristics, monitor ulcer for signs of progression or declination, and provide wound care per treatment order. The Wound Assessment Details Report, dated 12/12/23, documents the sacral wound is a stage three and measures 1.3 cm x 1.3 cm x 0 cm. It is 100% bright pink or red tissue with no signs of infection. The Wound Physician note, dated 12/19/23, documents the unstageable sacral wound measures 1 cm x 2 cm x 0.1 cm and is considered stable. There are no signs of infection. The Wound Assessment Details Report, dated 1/1/24, documents the sacral wound is now classified as unstageable and is 100% soft necrotic tissue with no signs of infection. It measures 13.5 cm x 9.5 cm x unknown. The Wound Physician note, dated 1/2/24, documents the unstageable wound to the sacrum measures 13.5 cm x 9 cm by unknown and is 10% granulation tissue in 90% eschar. No signs of infection or noted. The Wound Physician note, dated 1/25/24, documents the unstageable sacrum wound measures 10.5 cm 8 cm by unknown and is 25% elation tissue with 75% sloth. There's no signs of infection. (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Wound Physician note, dated 1/30/2,4 documents the unstageable wound to the sacrum measures 10.5 cm x 8 cm by unknown and is 25% granulation tissue with 75% slough and no signs of infection. The Wound Assessment Details Report, dated 1/31/24, documents the sacral wound is still in stable and measures 10.5 cm x 8 cm by unknown and is 25% bright pink or red with 75% soft chronic tissue. There is no odor documented. This wound is considered improved on this day. The Wound Physician note, dated 2/6/2024, documents the unstageable sacral wound measures 10.5 cm x 10 cm by unknown indicating the wound grew in size from the last assessment. The healing status is documented as declined. The wound is 25% granulation tissue was 75% eschar. The physician does not document any signs of infection nor a foul odor. There's no documentation that the foul odor was addressed on this day. A Wound Care note, dated 2/6/24, documents plan of care was revised to the left back thigh, sacrum, left outer ankle, and left outer thigh. A Nursing note, dated 2/12/24, documents R6 was picked up via transport and accompanied by a family member to the wound care clinic. Later that evening, a family member called the facility to let them know R6 was being admitted at the hospital for wound debridement. There is no documentation in the nursing notes that a foul odor was identified during rounds with the physician, or when the nurse changed the dressing. The Treatment Administration Record, dated 02/2024, documents there was an order change to the sacral wound on 2/7/24. Dressing changes were not completed on 2/10/24, 2/11/24, and 2/12/24. The Hospital Records, dated 2/12/24, document R6 was sent to the hospital for a wound evaluation of the sacrum. A CT (Computer Tomography) scan showed abscess formation in the gluteal muscles on each side of the sacral wound. It is documented the sacral wound also had a foul odor. The sacral wound was debrided in the operation room, where the abscess were also drained. R6 had a peripherally inserted central catheter (PICC) placed in the left arm for a needed course of six week of IV antibiotics. On 3/27/24 at 11:35AM, V12 (Wound Care Nurse) stated R6's dressing change order was revised to be done daily because that was the family request. V12 reported the sacral wound plateaued and became more necrotic. V2 denied being aware of any signs or symptoms of infection in that wound. V12 stated, If a wound is showing any signs or symptoms of infection, then the physician is notified, and usually the wound is cultured. If there is a bad odor, more drainage, or any other changes that we didn't notice before that are causing a decline, staff should let the physician know. Dressing changes should always be performed as ordered so the wound has the best chance of healing. On 3/27/24 at 3:23PM, V18 (Wound Physician) stated V18 did not remember seeing any signs or symptoms of infection in R6's sacral wound. V18 denied being notified of any changes in the wound. V18 reported, If there are any changes to a wound, then a resident is sent to the hospital for evaluation. Changing the dressing orders to once a day was based off family request. If a resident is having signs of the wound being infected, then it needs to be addressed immediately so it doesn't get worse. (continued on next page)

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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 - Actual harm Residents Affected - Few	On 3/28/24 at 3:28PM, V20 (Nurse) stated floor staff is a responsible for completing dressing changes when wound care nurses are not in the building. V20 remembered the dressing change frequency was revised towards the end of R6's stay at the facility, due to more necrotic tissue. V20 reported the wound was declining, so the physician kept trying different treatment plans. V20 denied any symptoms of infection while taking care of R6. V20 stated signs of infection would be redness, increased drainage, discoloration, or a bad smell. V20 denied remembering R6's sacral wound ever having a foul smell. V20 reported the dressing changes populate on the TAR (Treatment Administration Record), so staff nurses know what to do, and dressing changes should always be completed as ordered. V20 stated if it's not charted TAR then it has to be considered not done. V20 reported any changes to the wound should be discussed with the doctor so everyone can be on the same page. On 3/28/24 at 3:46PM, V21 (Nurse) stated V21 only changed R6's dressing maybe two or three times. V21 denied noticing any signs or symptoms of infection in the sacral wound. V21 reported signs and symptoms of infection could be swelling of the wound, increased drainage, redness, or an odor. V21 stated any changing condition to the wound, then the physician must be notified to see if there are any new orders to follow up. V21 reported treatment order should always be followed in the dressing changes need to be completed on the days they are due. V21 stated If the dressing changes is not charted on the TAR, it means it wasn't done. V21 denied R6 having any signs of infection the last time V21 took care of R6. On 3/29/24 at 11:11AM, V22 (Wound Physician) stated, If a resident has an abscess that is spreading to the gluteal muscles, then they need to undergo debridement at the hospital, likely in the operating room, to make sure everything is cleared out. Abscesses happen when the necrotic material is not eliminated or removed quickly enough, and it spreads to healthier tissue because there is no way for it to drain out. If a resident develops an abscess, staff would see an overall general decline in the appearance of the wound, it would hurt more, and it may or may not have signs of infection. There should be at least something telling you that you have an issue going on behind the wound. V22 reported dressing changes always need to be completed as ordered. V22 stated daily dressing changes are done at wounds that are more concerning and need to be assessed for any changes more frequently. V22 reported, Although there are many factors, an abscess can develop in as soon as 48 hours. On 3/29/24 at 3:55PM, V2 (Director of Nursing/DON) stated dressing changes should always be completed unless a resident refuses. V2 reported this allows staff to assess the wound. V2 stated if the dressing changes aren't being completed as ordered, then the wound is not being assessed properly. The policy titled, Skin Condition Assessment & Monitoring - Pressure and Non Pressure, dated 6/8/18, documents, Purpose: To establish guideline for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries, and other non-pressure skin conditions and assuring interventions are implemented. Wound Assessment/Measurement: . 3. Dressings will be checked daily for placement, cleanliness, and signs and symptoms of infection . 7. Physician ordered treatment shall be initialed by the staff on the electronic Treatment Administration Record after each administration. 8. A licensed nurse shall observe condition of the wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 40102 Based on interview and record review, the facility failed to develop an effective plan of care to include monitoring to prevent a dementia resident assessed to be at high risk for falls from falling, and failed to ensure facility staff provided safe bed mobility while providing direct resident care. This affected two of three residents (R1, R2) reviewed for fall prevention and safety. This failure resulted in R1 suffering a right sided pelvic fracture, and resulted in R2 sustaining a laceration to the head that needed to be repaired with Dermabond at the hospital. Findings Include: 1. R1 is an [AGE] year old with the following diagnosis: dementia, encephalopathy, weakness, lack of coordination, heart failure, and chronic kidney disease stage 3. R3 is an [AGE] year old with the following diagnosis: type 2 diabetes and chronic obstructive pulmonary disorder. The Minimum Data Set, dated dated [DATE], documents a Brief Interview for Mental Status score at 6 (severe cognitive impairment). The Functional Abilities and Goals, dated 11/14/23, documents R1 is partial/moderate assistance with toileting hygiene. R1 is supervision or touching assistance with bed mobility and sitting on the side of the bed. R1 needs partial/moderate assistance with going from a sitting to a standing position and with transfers. The Care Plan, dated 12/7/22, documents R1 is at high risk for falls. An intervention documented after the fall on 12/2/23 is documented as a call don't fall sign was placed in R1's room. There is no documentation of what kind of monitoring R1 requires. This care plan also documents R1 has impaired cognitive function/dementia or impaired thought process related to dementia. A Nursing note, dated 12/2/23, documents R3 informed the nurse R1 had fallen a couple days ago. R3 observed R1 moaning in pain. Upon assessment, R1 indicated pain around the right hip. An order for an x-ray was given by the physician. The Fall Report, with no date, documents R3 informed the nurse R1 had fallen a couple days ago. R1 was assessed and indicated pain around the right hip area. The physician was notified and placed an order for an x-ray. R1 is alert and oriented to person only. The Post Fall Observation, dated 12/2/23, documents R1 fell in R1's room, but it was unable to be determined what R1 was doing immediately prior to the event. The fall was witnessed by R3. R1 was not able to say what happened. Pain was noted to the right hip. The x-ray report, dated 12/3/23, documents the x-ray of the right hip showed an acute/recent minimally displaced fracture of the right inferior pubic ramus. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Hospital Records, dated 12/2/23, document R1 was sent to the hospital for an evaluation after a pubic ramus fracture was found on an imaging study at the hospital. R1 complained of right thigh pain. R1 is at normal baseline, but pain was noticed while staff was cleaning R1. The x-ray of the right hip showed a possible fracture of the right femoral neck, and a CT (Computer Tomography) scan is recommended for further assessment. This was discussed with the facility. R1 was discharged back to the facility with a recommendation to follow up with ortho. A Serious Injury Incident and Communicable Disease Report, dated 12/11/23, documents R1 had a fall with physical injury. R1 is oriented times one. On 12/2/23 at approximately 8 PM, R3 reported to the CNA R1 had a fall in the bathroom a few days ago. R1 was assessed and complained of pain to the right hip. The physician was notified and gave an order for an x-ray of the pelvis. The x-ray was completed and showed a fractured to the right inferior pubic ramus. A new order was placed by the physician to send out one to the hospital for further evaluation. It was determined R1 uses a wheelchair due to unsteady gate. R1 is impulsive with poor safety awareness. R1 requires partial to moderate assistance with transfers and ADL care. R3 reported that a couple days ago R1 attempted to self ambulate to the bathroom and fell . R1 got up from the floor and ambulated back to the bed. R1 was diagnosed with a pelvic fracture in order to follow up with ortho from the hospital. On 3/19/24 at 1:46PM, R1 was sitting in a wheelchair watching TV in the dining room being monitored by staff. R1 denied any problems in the facility, and denied having any pain. R1 was not able to remember having a fall back in December. R1's mental status was assessed. R1 stated the date was 2006, but R1 was not able to state president or location. R1 denied having broken pelvis. R1 denied needing any help walking and reported getting up alone to walk when R1 needs. On 3/19/24 at 2:49PM, V3 (Nurse) stated R3 reported R1 fell , but reported it days after it happened. V3 reported an x-ray was taken, and showed a fracture so R1 was sent to the hospital. V3 admitted R1 is confused and only alert and oriented times one. V3 stated R1 will try to get up to walk alone without any assistance, but once staff see, they sit R1 back in the wheelchair. V3 reported being unable to speak on monitoring due to not knowing when R1 exactly fell . On 3/19/24 at 3:55PM, V4 (CNA) stated V4 was not aware of any falls R1 had in the past. V4 reported R1 is transferred to the wheelchair, then taken him to the bathroom and transferred to the toilet. V4 stated R1 likely, would not be able to walk to the bathroom alone due to being too weak, and only being able to walk short distances. V4 confirmed R1 was confused and will attempt to get up alone. V4 stated R1 is kept in areas where staff can better to monitor R1 safety. V4 reported if R1 is in R1's room alone, then staff try to monitor R1, but denied any set monitoring schedule. On 3/19/24 at 5:36PM, V8 (Nurse Practitioner) stated R1 had a fall in R1's room, and R3 notified staff leader of what happened. V8 reported the imaging showed fracture to the pelvis, and these type of fracture are usually caused by some kind of impact. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/20/24 at 1:35PM, V9 (Restorative Nurse) stated this fall was reported by R3, and had happened a couple days prior to being reported. V9 reported an x-ray was completed of the hip and showed a pelvic fracture. V9 stated R1 was sent to the hospital and returned with in order to see orthopedics. V9 stated R1 needs partial to moderate assist with transfers and toileting, but is supervision only with bed mobility. V9 admitted R1 has an unsteady gate, but is able to walk. V9 reported the root cause of the fall was R1 ambulated to the bathroom alone, and fell . V9 denied R1 being able to tell V9 anything about the fall. V9 stated R1 is currently a high fall risk, and was a high fall risk prior to this fall. V9 reported R1 is a high fall risk because of an unsteady gate, periods of confusion, and gets up without calling for assistance. V9 stated normally residents monitored every two hours but for high fall risk residents staff tries to monitor them every one to two hours. V9 denied having any documentation of where the monitoring is in the computer system, or documenting it as an intervention. V9 stated, We just try to have staff keep an eye on them as they pass the room. On 3/20/24 at 4:02PM, V2 (Director of Nursing/DON) stated, This was not witnessed, and the only way staff was made aware of the fall was by (R3) a couple days later. V2 reported the x-ray showed a fracture to the pelvis. V2 stated a root cause was not able to be determined, because they couldn't even determine if R1 actually fell , but a nurse practitioner did say the fracture was likely due to trauma. V2 admitted R1 will get up without assistance. V2 denied R1 being unsafe. V2 was not able to give an exact timeframe of when high fall risk resident should be monitored, but stated it is more than two hours. On 3/29/24 at 1:39PM, V23 (Primary Physician) stated V23 did not remember this fall, but reported the imaging report showed a fracture to the pelvis. V23 confirmed these type of fractures usually happen from some type of blunt force trauma. V23 said, It could happen from a fall or some other type of injury where the pelvis has some type of impact. The facility tries to give the residence as much autonomy as possible. Without restrictions and residents are allowed to fall, but they should not be getting hurt. This, unfortunately, was a mechanical fall with injury, but we were trying to give the resident as much autonomy as possible. 2. R2 is an [AGE] year old with the following diagnosis: spinal stenosis, weakness, lack of coordination, and lymphedema. The Functional Abilities and Goal Assessment, dated 11/30/23, documents R2 needs substantial/maximal assistance with toileting hygiene. The Care Plan, dated 11/20/22, documents R2 is at high risk for falls related to decreased mobility, balance, and mobility. Interventions were updated on 12/26/23 after the fall, with bilateral fall mats and restorative bed mobility. The Minimum Data Set, dated dated [DATE], documents a Brief Interview for Mental Status score of 11 (moderate cognitive impairment). A Nursing note, dated 12/26/23, documents R2 had a fall and to check the post fall observation form for more information. R2 was sent to the hospital and returned around in stable condition. A Nurse Practitioner note, dated 12/27/23, documents R2 had a fall yesterday with a laceration to the forehead. R2 was sent out to the hospital for evaluation and returned with no acute findings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Hospital Records, dated 12/26/23, documents R2 presented to the emergency department status post fall. R2 stated falling out of bed while R2 was being changed. R2 had a laceration to the head that was 6 millimeters. The laceration was repaired with dermabond. The Fall Report, dated 12/27/23, documents the nurse was called to the room and was found on the floor with bleeding to the head. R2 was assessed and got back to bed. 911 was called and transferred to the hospital. R2 and the CNA (Certified Nursing Assistant) reported when R2 was rolled on R2's side, R2 slid off the bed striking R2's face on the floor causing a laceration. Bilateral fall mats will be placed while R2 is in bed. The Serious Injury Incident Report, dated 1/2/24, documents R2 fell on [DATE] around 5:00AM by rolling out of bed during morning care. R2 bumped R2's head on the floor causing an opening to the skin on the forehead. On 3/19/24 at 1:37PM, R2 reported having a fall the day after Christmas. R2 stated R2 rolled off the bed while being changed by a CNA, and R2 hit R2's head on the floor. R2 reported R2 was bleeding from the head. R2 stated R2 was sent to the hospital, where a CT scan of the head was completed but was negative. R2 reported needing the laceration to the head glued in order for the bleeding to stop and the wound to be closed. There now is a scar about 1 inch by 0.5 inches in the top, middle of the forehead. R2 stated while being changed by a CNA, R2 was turned too close to the edge and fell off the bed. R2 reported R2 is not able to turn over in bed without assistance due to being weak. R2 stated the CNA then ran out of the room and got a nurse to come help. R2 reported the nurse called 911 and R2 left the facility but returned the same night. R2 reported having a headache and feeling dizzy. On 3/19/24 at 4:07PM, V5 (CNA) stated V5 was getting everything ready to provide morning care to R2, when V5 raised the head of the bed. V5 reported proceeding to roll R2 away from V5 while using the draw sheet. V5 stated, I held (R2) with one hand, and was going to provide pericare with the other hand. As soon as the wipe touched (R2), (R2) jumped and fell off the bed. V5 stated nothing was next to R2's bed at the time of the fall, and R2 had a cut on R2's head that was bleeding. V5 reported R2 needs assistance when turning over in bed and cannot do it alone. V5 stated, I don't know how she didn't know she was too close to the edge. V5 reported attempting to pull R2 back into the bed as R2 was falling, but was unsuccessful. On 3/19/24 at 4:18PM, V6 (Nurse) stated V6 was alerted by V5 that R2 fell from the bed. V6 reported R2 had a laceration to the head. V6 stated calling 911 due to R2's had bleeding. V6 reported V5 told V6 that R2 jumped and rolled out of the bed while V5 was providing care. On 3/20/24 at 1:35PM, V9 (Restorative Nurse) stated, The intervention put in after this fall, was to work with restorative to familiarize (R2) with the boundaries of the bed. V9 confirmed R2 needs partial to moderate assistance when rolling in bed and positioning R2. V9 reported R2 went to the hospital to get a laceration repair. On 3/20/24 at 4:02PM, V2 (DON) stated this fall was witnessed and happened during patient care. V2 reported R2 jumped while V5 was providing incontinence care, and R2 jumped off the bed. V2 stated R2 needs assistance with repositioning in the bed due to not being able to do it alone. V2 reported CNAs we're educated on bed mobility and had to do a return demonstration of how a resident should be positioned during care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/29/24 at 3:29PM, V24 (Primary Physician stated) V24 does remember R2 having a fall where R2 hit R2's head. V24 denied remembering how R2 fell off the bed. V24 reported not being able to remember all detailed about the fall, but stated if R2 was not as close to the edge of the bed, then maybe R2 would not have fallen out. V24 stated, The residents have a right to fall, but we need to try to prevent injuries as much as possible. The policy titled, Fall Prevention Program, dated 11/21/17 documents, Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary .In addition to the use of Standard Precautions, the following interventions may be implemented for residents identified at risk: The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care.