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Form Approved OMB
No. 0938-0391

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	11/07/2024

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 0689 Level of Harm - Minimal harm or potential for 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** 41758 Based on interview and record review, the facility failed to monitor and supervise to prevent a resident (R1) from leaving the facility unauthorized who assessed to have supervised pass privileges. This affected one of three residents (R1) reviewed for supervision. This failure resulted in the resident exiting the facility unauthorized on 10/17/24, at 4:45pm via the front lobby entrance without staff intervention and being gone approximately fourteen hours without staff knowledge of whereabouts. Findings Include: R1 was admitted on [DATE] with Right Patella (kneecap), Tibia (shin bone), upper and lower Fibula (long thin bone in lower leg), displaced bimalleolar (ankle) fracture of right lower leg , displaced fracture of seventh cervical vertebra, wedge compression fracture of the first lumbar vertebra, fracture of manubrium (upper wide handle like part of the sternum), multiple fractured ribs, right side, fracture of one left side rib after a motor vehicle collision, history of substance abuse and alcohol use. Minimal data set date section C (cognitive patterns) dated 10/16/24 documents a score of fifteen which indicated cognitively intact. Section GG (functional abilities) documents: impairment on one side: Lower extremity (hip, knee ankle foot) walking ten feet or one step (curb) not attempted due to medical condition or safety concerns. Physician order sheet dated 10/10/24 documents: Right Lower Extremity, Non-weight Bearing, Left lower extremity weight bearing as tolerated. Nursing note dated 10/17/24 documents - 1700 (5:00pm) -The CNA (Certified Nurses Assistant) rounded on the resident and obtained vitals and rendered care. 1730 (5:30pm) -Resident was ambulating with her walker stating to the writer that she was getting exercise in the hallway. 1900 (7:00pm) - During the medication pass, the writer noted the resident (R1) not in her room. Resident dinner tray untouched in her room. The resident was last seen with her male companion in her room. Staff noted the resident's cold therapy equipment related to her extremity abnormalities was no longer in her room. The resident does not have a pass to leave the facility. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 12:20PM, V5 (RN/Registered Nurse) said, she rounded on each resident's when she reported to work. V5 said, she went into R1's room. R1 was in her room. Ten minutes later, R1 was seen in the hallway, on crutches and walking. R1 reported she was getting some exercise. V5 said, she did not think anything of seeing R1 walking. V5 said, it was medication pass when she went to R1's unit. V5 said, she was across the hall from R1's room when V6 (Social Service Coordinator) reported, that R1 was not in her room, R1 left. V5 said, V6 did not speak with any urgency or concern. V5 said, she informed V7 (nurse supervisor) R1 was gone. R1 did not have a pass to go out. V5 said, the last time she saw R1, she was in the hallway. V5 said, she was on that end of R1's unit where she was passing medication around 4PM. V5 said, R1 did not express any desire to leave nor did she get report prior to the incident that R1 wanted to leave. The lobby front doors opened automatically. If a resident wants to go out on pass, the doctor has to give an order for the resident to go out, resident has to be physically and mentally able to go out on pass. There is a twenty-four hour wait period before that resident can leave after getting the order, that did not happen for R1 or in this case. If a resident goes out against medical advice (AMA), they need to complete an AMA form. R1 did not complete that form. R1 left the facility at the beginning of her shift around four something. On 10/25/24 at 12:27PM, V6 said, R1 asked about going out on pass around 11:30AM. R1 said, she had a funeral to attend. R1 was educated if she wanted a pass she needed a doctor's order. V6 said, R1 has a history of alcohol and substance abuse. R1 reported using illegal drugs recently. R1 was informed the doctor may see the drug use as a barrier for getting a pass. V6 said, later that same day, staff informed her that she saw R1 leaving the building. V6 said, she did not see R1 leave the facility. V6 said, when she walked pass R1's room the lights were off. V6 said, she asked where R1 was and was informed R1 was getting some exercise. V6 said, R1 was in the lobby doorway with her walker. V6 said, she thought R1 had a pass. V6 said, she saw R1 stand in the lobby doorway but she did not see R1 leave. R1 left the facility unauthorized. On 10/25/24 at 12:58PM, V1 (Administrator) said, we viewed the lobby camera which showed R1 coming out of her hallway and exiting the building via the lobby front doors. R1 left against medical advice (AMA.) R1 was alert and oriented times four. V1 said, we spoke to R1's family who did not know R1's location. V1 said, they called the hospitals. V1 said, V2 (DON/Director of Nurses) connected with R1 via the phone the next day. The incident was not reported to public health because we didn't have to it wasn't an elopement. On 10/25/24 at 1:19PM, V4 (CNA) said, R1 left suddenly. V4 said, during rounds she didn't see R1 so she asked the nurse about R1's whereabouts. V4 said, the lobby doors used to open automatically, no one was buzzed out of the facility prior to R1 leaving. On 10/25/24 at 1:34PM, V9 (SSD/Social Service Director) said, she doesn't know who saw R1 leave. Around 7:45pm, V9 said, V6 was at the nursing station asking V7 (RN) about R1's whereabouts. V9 stated, the receptionist should be at the desk at all time's for safety. The front lobby doors were motion sensored. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 3:32PM, V2 (DON) said, R1 was planning to go to a funeral. V2 said, she got a called from V7 who reported, R1 wasn't in the facility. V2 said, we started a code green, did a head count to make sure R1 really wasn't in the building. R1 was not in the building. R1 was ambulatory with an assistive device. We called R1 and left messages. R1 called back the next morning. V2 said, R1 did not tell her where she was. V2 said, the camera was reviewed. R1 was seen walking out of the facility. R1's male friend was seen walking out with R1's belonging's and ice machine on his left arm, then R1's friend was seen walking to parking lot. V7 did a code green for a head count as an elopement precautionary measure. The CNA noted R1 wasn't in the building at 5pm. We do not notify the police for AMA. We notify the police for elopement. The AMA policy was not implemented because R1 did not verbalized that she wanted to leave prior to leaving. If a resident does not verbalized they want to leave and leave, it's not an elopement if they are alert and not an elopement risk. R1 was cognitively intact and decisional. V2 said, she wouldn't trust R1 to be alone on the community by herself but she left with her visitor. Local Police Department wasn't able to do a well check on R1. V10 (receptionist) could have checked to see if R1 had a pass. Generally the nurse will call down or the receptionist will call up to determine if a resident has been given a pass.V2 said, she doesn't know what time R1 left the facility, it had to be right before she received that call from V7 at 7pm. On 10/25/24 at 4:12PM, V3 (CNA) said, she started working at 3pm. V3 said, she did her rounds and vitals. V3 said, she said saw R1 at that time. R1 had a visitor, R1 allowed V3 to take her vitals. V3 said, it takes an hour to complete vitals. V3 said, she got busy with another resident and it was almost dinner time. V3 said, she collected the trays and noticed R1 wasn't in her room. R1 did not eat her tray. V3 said, she observed that R1 was gone. R1 had a plastic bag in the sink with her toiletries in the bag. V3 said, she reported to V7. A code green was called and all rooms were checked. V3 said, R1 was a fall risk. Tray pickup was completed by 6:30pm. V3 said, she has never seen R1 walk. On 10/25/24 at 4:27PM, V10 (receptionist) said, she was informed R1 left between 4PM-4:10PM. V10 said, after V1 reviewed the camera, she was informed R1 left on her shift and she didn't stop R1. V10 said, she did not know R1, would not recognize R1 and had no way of telling who was a resident or who was a visitor. V10 said, she asks visitors to sign in and out but sometimes they will not do it. V10 said, we are supposed to stop any residents leaving the front door if they are not accompanied by a staff. On 10/29/24 at 11:00AM, V21 (OT/Occupational Therapy) said, R1 had an unusual gait. R1's right leg was longer than the other. R1 walked backwards and on an angle dragging her right leg. R1 was not weight bearing to the right leg. On 10/29/24 at 11:03AM, V22 (PTA/Physical Therapy Assistant) said, R1 was non-weight bearing to the right leg. R1 had a significant length discrepancy. V22 said, R1 was not able to take steps without violating her non-weight bearing status. V22 said, he would hold R1's leg up while she used the parallel bars. V22 said, R1 walked sideways and was always advised against it. R1 was not safe ambulating. V22 said, he was informed R1 was ambulating in the hallway. V22 said, R1 should avoid walking at all cost. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PT (Physical Therapy) notes dated 10/11/24 start of care documents: Ambulation not attempted due to medical condition (ambulation non-weight bearing (NWB) on right lower extremity(RLE) with pick up walker (PUW.) Patient (Pt) had a significant leg length discrepancy. Pt was attempting to hop sideways to clear foot. Pt would prefer not to use wheelchair (w/c) but was educated that she would need one for long distance to get through building. On 10/29/24 at 11:26AM, R1 who was assessed to be alert and oriented to person, place and time said, she smiled at the receptionist and walked out through the front lobby doors slowly. R1 said, it took a few minutes to walk out. R1 said, she did not tell anyone she was leaving. R1 said, she puts her mind to it (walking out) and she did it. On 10/31/24 at 12:20PM, V10 said, she did not see R1 leave, she was helping two people who were standing at the desk. V10 said, she would have asked R1 to sign out had she seen her but she did not. R1 said, she was given a corrective action form and told she was at the desk and saw R1 walk out after the camera was reviewed by management. On 10/31/24 at 10:54AM, V1 (Administrator) said, R1 left building between 4:45pm -5:10pm. SOC Admissions assessment dated [DATE] documents: The resident DOES NOT appear to be capable of unsupervised outside pass privileges at this time. Pt has a history of drug and alcohol abuse. Also, Pt will receive therapy services to get stronger. The resident has extensive care needs secondary to physical disabilities. Does the resident have the physical ability to leave the facility? No. Is there a history with alcohol, street drugs, prescription or over the counter drugs, nicotine/tobacco? Yes. Facility Action in Response to R1 AMA documents: Administrator reviewed camera and observed resident in the lobby ambulating with walker. After review, we determined that R1 left 4:40-4:45 pm. Employee Disciplinary Report dated of incident 10/17/24 documents: Improper conduct: On 10/17/24, V6 observed resident (R1) in exit door and did not check that resident was allowed to leave without an escort and pass. Action to be taken: suspension one day 10/23/24. Refuse to sign. Employee Disciplinary Report dated of incident 10/17/24 time of incident appropriately 4pm documented failure to follow instruction: V10 was not alert to resident attempting to leave the building. Action to be taken: suspension. V10 verbally acknowledged acceptance in serviced via phone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Police report dated 10/17/24 documents: Occurred Between: 5:00pm 10/17/24 and 1131pm 10/17/24. R1. Missing. On Thursday, 10/17/2024 at approximately 11:29 PM, Officer was dispatched to nursing home. Officer met V7 regarding missing resident (R1) missing adult. Upon my arrival, V7 stated the following to the officer in summary and not verbatim: on 10/17/2024, R1 voluntarily left the facility at approximately 5:00 PM. Officer was advised R1 left the facility without receiving a Day Pass and no contact has been made since. V7 stated she attempted to contact R1 via phone calls and text, but only received a text message back, from the number assumed to be R1 stating, this not R1, this her family. When V7 asked the family if she had contact information for R1, she did not get a response back. V7 was advised to call local police department and have an officer go by the residence to see if they could make contact with someone and if so, to identify them. According to nursing home policy, if a person voluntarily leaves the facility without a day pass and does not return by 10:00 PM, they are considered missing. Therefore, V7 signed a Police Department L.E.A.D.S. Authorization Form, allowing for R1 to be entered as missing. R1 also has a fractured right leg, but is fully ambulatory and reported to have a drinking problem. It was also mentioned that an unknown male came to visit R1 earlier that day, however, they cannot say, with certainty, R1 left the facility with him.

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their physician notification of laboratory/radiology/diagnostic results policy by not notifying the physician/nurse practitioner of a sacral wound culture results indicating high amount of bacteria (greater than 100,000 pseudomonas aeruginosa) for one resident (R2) who had a stage three sacral pressure ulcer. This affected one of three (R2) residents reviewed for notification of an abnormal lab result. This failure resulted in R1 not receiving any antibiotic treatments and being hospitalized two weeks later with a diagnosis of sacral osteomyelitis. Findings include: R2 was admitted to the facility on [DATE] with a diagnosis of sepsis, pressure ulcer of sacral region stage three, quadriplegia, anemia, muscle wasting and adult failure to thrive. R2's wound assessment dated [DATE] by V14 (Wound NP/Nurse Practitioner) documents: pressure injury stage three to coccyx measuring 5 centimeters (CM) length x 4CM width x 0.1cm depth. 60 % granulation and 40 % sloth. Signs and Symptoms of Infection: documents odor. Comments: obtain wound culture and labs, consult Infectious disease. R2's progress note dated 10/3/24 documents, seen per wound MD (Medical Doctor) with coccyx assessed with positive malodor and onset green tinge to drainage, wound culture obtained, V17 (Infectious Disease/ID, NP) consult initiated, V17 (ID NP) notified. On 11/1/24 at 11:28AM, V15 (previous Wound Care Coordinator) said she recalls R2's wounds declining and ordering wound culture. V15 said usually V17 (NP) will follow up with the results and order an appropriate treatment. V15 said she is not sure what happened and does not recall any other information related to R2's culture result. V15 said she does not recall informing or following up with anyone related to R2's wound culture results. On 10/31/24 at 12:34PM, V17 (ID NP) said he did receive a message for consult on 10/3/24 but unsure why R2 was not seen. V17 said usually the ordering physician would be notified of culture results. V17 said he was not aware of R2's wound culture results and would have ordered antibiotics for R2. On 10/30/24 at 2:55PM, V14 (previous Wound MD) said her last visit with R2 was on 10/3/24 and she did not return for any services at the facility. V14 said she ordered the wound culture due to wound declining and signs of infection. V14 did not receive any culture results for R2. V14 said at the facility they will consult Infectious Disease for further management to determine right antibiotic. V14 said she would usually follow up the next visit to see what antibiotic the patient was on or follow up with results. V14 said it is possible for the wound to get worse if there was an infection but unable to determine exact cause of infection. R2's facility wound assessment report dated 10/4/24 documents: stage 3 pressure ulcer. Under odor and signs of infection present it documents yes. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	R2's wound care note dated 10/11/24 by V13 (Wound NP) documents sacral pressure ulcer stage 4 measuring 8 centimeters (CM) length x 8.5 cm width x 2 cm depth. Necrotic tissue 90% slough 10%. wound debrided post debridement size measuring 8 centimeters (CM) length x 8.5 cm width x 2.3 cm depth. On 10/30/24 at 1:32PM, V13 (Wound MD) said his initial visit of R2 was on 10/11/24. V13 said he was not notified of any culture results for R2 at time of visit or after. On 10/31/24 at 1:28PM, V2 (DON/Director of Nurses) said for wound culture orders, the wound care nurse would obtain culture and send out to the lab. Floor nurse would receive the results and relay the results to primary care physician who would determine any orders. On 10/31/24 at 2:15PM, V2 (DON) said she did receive an email for R2's culture result but unsure what happened with the follow up. On 11/1/24 at 11:44AM, V19 (MD) said he does not recall getting notified of wound culture results for R2. Usually, the ordering physician is notified of the results, but staff should always call him with any results. If there was a need for treatment V19 said he would have ordered the appropriate antibiotics but sometimes the culture can be colonized, and treatment is not needed. Osteomyelitis can occur from the wound progression and infection. R2's development of osteomyelitis can be a combination of both infection and declining wound status and unable to determine the exact cause. V19 said there should have been sooner intervention in relation to the wound culture results but unable to determine if the interventions were placed if R2 would have not gotten osteomyelitis given the overall wound progression. R2's medical record under lab results documents wound culture collected 10/3/24, reported date 10/7/24 with reviewed status. Wound pathogen panel dated 10/7/24 documents: pseudomonas aeruginosa, staphylococcus aureus and streptococcus agalactiae detected. Positive. Printed 10/11/24. R2's final lab report dated 10/7/24 documents: coccyx wound culture results indicating high amount of bacteria greater than 100,000 of pseudomonas aeruginosa. V14(previous Wound NP) is listed as physician. On 11/1/24 at 9:04AM, V18 (Lab Director of Operations) said results were sent to facility on 10/7/24 but the whole report did not send. V18 said the full results were emailed to the facility on [DATE]. V18 said they will recommend treatment for any result indicating high. R2's progress note dated 10/25/24: seen per wound MD with coccyx assessed, bedside debridement performed to promote wound healing, malodor persists. R2' medication administration record and physician orders did not document any new antibiotic treatment after 10/7/24 -10/26/24. R2's braden score dated 9/15/24 documents a score of 13 which indicates moderate risk for skin breakdown. R2's hospital record dated 10/26/24 documents under diagnosis: Sacral osteomyelitis. R2's facility wound assessment reports dated 10/15/24 and 10/22/24 documents under odor: yes, signs of infection present: yes. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	R2's plan of care initiated 8/19/24 documents: R2 has pressure injury to coccyx, is at risk for delayed wound healing and is at risk for further alteration in skin integrity related to immobility muscle wasting, quadriplegia, R2 has history of sepsis, anxiety asthma, fever, bedbound, wounds present on admission. Varied compliance with repositioning. Limited tissue perfusion at the point of pressure immobility and infrequent offloading. Adult failure to thrive and skin failure. Interventions include: monitor for signs and symptoms of infection (redness, warmth, swelling, pain, excessive drainage, odor) and notify provider. Date Initiated: 08/20/2024 ; Ongoing assessment of wound to evaluate signs of deterioration or improvement and possible change of treatment. Date Initiated: 08/20/2024. Facility policy Physician notification of laboratory/radiology/diagnostic results revised 7/8/24 documents: to assure the physician ordered tests are performed, and to assure test results are reported to the ordering physician so that prompt, appropriate action may be taken if indicated for the residents care. A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the primary care physician or other ordering practitioner. In the event a physician does not respond promptly the alternative physician or medical director will be notified.