STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145683	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Abington	3901 Glenview Road Glenview, IL 60025

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure that no medications are kept at the resident's bedside without physician order. The facility also failed to assess a resident for safe medication self-administration. This deficiency affects one (R8) of three residents in the sample of 25 reviewed for Medication safety. Findings include: On 4/1/25 at 11:40AM, While observing V15 LPN (Licensed Practical Nurse) administering oral medication to R8 observed the following medications not labeled on her bedside tray table: one (1) triamcinolone acetamide lotion 0/1% 60 ml, two (2) nasal (deep sea) spray bottles and (3) Caladryl lotions. R8 is alert, oriented x 3 and can verbalize needs to staff. R8 said that she has been taking these medications in her room. She said she has rashes to her both hands/arms, as she pulled up her sleeves and showed her rashes with redness. She said that she applied triamcinolone and caladryl for her rashes and itchiness on both arms/hand every day and as needed. She said she uses the nasal spray 2- 3 times per day and as needed. She said that nurses are aware that she has been taking all of these medications. V15 LPN did not respond. On 4/1/25 at 3:07PM Informed V2 DON (Director of Nursing) of above observation. V2 said that a resident is not allowed to keep medication at the bedside without physician order. V2 said that resident self-administration of medication assessment should be completed to check if R8 is capable of self-administration of medication. Informed V2 DON that R8 does not have an order for Nasal (deep sea) spray and caladryl lotion. R8 does not have an order to keep medications at bedside. No resident self-administration of medication assessment was completed by Interdisciplinary team (IDT). She was not care planned for medication self-administration. R8 was admitted on [DATE] with diagnosis listed in part but not limited to Acute and chronic respiratory failure, Congestive heart failure, Paraplegia, Congenital deformity of spine, Spina Bifida, Allergic rhinitis. Active physician order sheet indicated Triamcinolone acetonide external cream 0.1% apply to upper back, BUE, shoulders, BLE topically every 8 hours as needed for itching. No order for Nasal (deep sea) spray and caladryl lotion. No order to keep medication at bedside. No resident self-administration of medication assessment completed by IDT. Facility's policy on Self- Administration of Medication effective 4/2014 indicated: Purpose: To establish guidelines concerning the self-administration of drug. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	General Guidelines: 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing by the attending physician. 2. Should the resident's attending physician permit the resident to administer his/her medications, the following condition should apply: c. A self-administration of medications assessment will be completed that indicates that the resident is capable of self-administering drugs. Facility's policy on Medication Storage revision date 7/2/19 indicated: Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes, and needles. Guidelines: 13. Bedside Medication Storage: 13.1 Facility should not administer/provide bedside medications or biologicals without a physician/ prescriber order and approval by the interdisciplinary care team and facility administration. 13.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room. Facility's policy on Resident rights reviewed 1/4/19 indicated: Purpose: To promote the exercise of rights for each resident. Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: *Self-administer medication, if the IDT care planning team determines it is safe.

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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 - Minimal harm or potential for 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** 39781 Based on observation, interview, and record review the facility failed to ensure ongoing assessment and monitoring are implemented to identify and report new open pressure ulcer for a resident who has history of pressure ulcer. The facility failed to notify the physician for appropriate treatment order. The facility failed to implement pressure ulcer prevention policy by not providing specialty mattress. This deficiency affects one (R22) of three residents in the sample of 25 reviewed for Pressure ulcer/Wound Prevention Management. Findings include: On 4/1/25 at 2:17PM, V16 (R22's Family member) said that R8 has pain on her buttocks, but she does not have pressure sore. The nurses applied cream and foam dressing for protection. Surveyor called V6 Wound Care Nurse to check on R22 sacral area. On 4/1/25 at 2:32PM, V6 Wound nurse repositioned R22 to her left side lying position to check skin integrity on R22's sacral area. Observed foam dressing applied to right buttocks. But observed open wound stage 2 /full thickness on sacrococcygeal area, 100% red tissues with whitish color/maceration on peri wound. V6 said it is a healed pressure ulcer. V6 said, he works on the floor and relieved V23 Wound Care Coordinator (WCC) to perform wound care. V6 said that he has not provided wound care to R22 today. V6 said, he has not seen R22 since Thursday last week. V6 said, V23 WCC applied the wound dressing yesterday. Surveyor called V18 ADON (Assistant Director of Nursing) to show new open wound observation on sacral area. V11 LPN (Licensed Practical Nurse) said that the treatment nurse does the wound treatment to R22. V11 is not aware that R22 has new stage 2 pressure ulcer on sacrum area. V11 said that CNA did not report to him that R22 has new open wound. On 4/1/25 at 2:55pm V6 and V18 repositioned R22 to left side lying position to assess skin integrity of sacral area. V18 said R22 has new stage 2 pressure ulcer on sacrum area. V18 measured open wound and obtained 0.5x 1x0.1 cm., 100% red tissue with maceration on peri wound. V18 said that when there is a new open wound, it should be assessed, notify physician for appropriate wound treatment, inform the family, document, and updated the care plan. R22 is readmitted on [DATE] with diagnosis listed in part but not limited to Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease or end stage renal, Parkinson disease, Dementia, Osteoarthritis and Dependence on oxygen supplement. Most recent Braden/skin assessment dated [DATE] indicated that she is at risk for developing skin impairment. Active physician order sheet indicated Sacrum: calmoseptine cream, foam dressing every day shift. Comprehensive care plan indicated that she is at risk for alteration in skin integrity related to medical diagnosis, fragile skin, incontinence of bowel, incontinence of urine, limited joint mobility and poor skin turgor. R22's March 2025 Treatment administration Record (TAR) indicated daily treatment to sacral area. Last wound assessment done on 12/23/24 indicated incontinence MASD (Moisture Associated Skin Disorder) active, erythema, pale pink non granulating 100%, no exudate, skin intact. No documentation found in chart after 12/23/24. Wound assessment completed on 4/1/25 by V18 ADON after surveyor identified open wound /Stage 2 pressure ulcer on sacrum indicated facility acquired pressure ulcer on 4/1/25, 100% pink/red granulating tissue, no exudate, macerated peri wound with attached and distinct edges, measures 0.5cm x 1cm x 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 10:50AM, V23 Wound Care Coordinator said she does the wound treatment, assessment, and wound measurement, and makes wound rounds with the wound care physician. V23 said V18 develops and updates the wound care plan. V23 said that she and V6 does the treatments for R22. V23 said, R22 does not have an open wound, they apply calmoseptine cream and foam dressing to sacrum as protection because she is at risk. She said that she did R22's wound treatment on 3/31/25 at 5:00AM and her skin is intact. V6 relieves her when she is off. Reviewed R22's medical records with V23. Informed V23 that R22's last wound assessment was done on 12/23/24 and indicated active MASD (Moisture associated skin disorder) with erythema on sacrum, no open sore. No documentation was found indicating healed MASD with no erythema. Informed V23 that she and V6 are providing daily treatment to her sacrum but no weekly skin documentation on the sacral area. Informed V23 that specialty mattress was not utilized as preventive measures; not until surveyor presented concern. Informed V23 of concerns identified that they failed to ensure ongoing assessment and monitoring are implemented to identify and report new open pressure ulcer of resident who is at risk for developing and has history of pressure ulcer. The facility failed to notify the physician for appropriate treatment order in a timely manner. Facility's policy on Pressure ulcer prevention revision dated 1/15/18 indicated: Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. May use lotion on dry skin. 9. Pressure reducing (foam) mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc., may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple stage 2 wounds or one or more stage 3 or stage 4 wounds. Facility's policy on Pressure injury and skin condition assessment revision 1/17/18 indicated: Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcer and assuring interventions are implemented. 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. 6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. 7. At earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to ensure an oxygen nasal cannula was properly in place for a resident who has an order for oxygen supplementation. The facility failed to change the empty concentrator's humidifier bottle in a timely manner. The facility also failed to follow physician order in administration of oxygen. This deficiency affects 3 (R22, R38 and R81) residents in the sample of 25 reviewed for Oxygen/Respiratory Management. Findings include: On 4/1/25 at 11:00AM, Observed R22 sitting in a wheelchair with oxygen not properly placed. The nasal cannula is placed on her right cheek. Oxygen tubing is dated 3/29/25 and is connected to an oxygen concentrator with a humidifier bottle that is empty. Showed observation to V11 LPN (Licensed Practical Nurse). He placed the oxygen cannula to R22's nasal/nostril and said he will replace the oxygen humidifier. On 4/1/25 at 2:17PM, Observed R22 with oxygen via nasal cannula at 2.5 LPM (liters per minute) with an empty humidifier bottle. V11 did not replace the empty humidifier bottle when observed empty this morning. Showed observation to V11. On 4/2/25 at 11:16AM, Informed V2 DON (Director of Nursing) of above observation. V2 said that humidifier is needed to prevent nasal dryness from oxygen usage. V2 said that oxygen humidifier bottle is replaced once the water is emptied. The oxygen via nasal cannula should be placed properly into resident nostrils to provide oxygen. R22 was admitted on [DATE] with diagnosis listed in part but not limited to Chronic diastolic congestive heart failure, Dependence on supplemental oxygen, Atrial fibrillation, Anemia. Active physician order sheet indicated Oxygen at 2LPM per nasal cannula continuously. Monitor every shift. Comprehensive care plan indicated she needs oxygen and respiratory treatment for shortness of breath/wheezing. Intervention: Provide oxygen as ordered. Monitor saturation every shift and as needed. Change oxygen tubing, humidifier bottle and oxygen tubing plastic holding bag as ordered. Facility's policy on Oxygen therapy: Purpose: To deliver oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. Indications for oxygen use via nasal cannula include: *Reverse the effects and symptoms of hypoxia *Decrease the work of breathing *Decrease the work of the heart Policy: It is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Equipment: *Humidifier *Flow meter *Delivery device (nasal cannula) *Oxygen source *NO smoking sign Procedure: I Physician order A. Verify physician order II Set up and administration of oxygen B. 2. Nasal cannulas should fit unto the nostrils unless contraindicated. 49871 On 4/2/2025 at 11:05 AM, R38 seated on his wheelchair doing active exercise for his legs and not using oxygen. Oxygen tubing and cannula inside the nightstand drawer, not stored in a plastic bag and humidifier/bubbler with a date of 3/22/25. On 4/2/2025 at 11:07 AM, V21 (Registered Nurse) said oxygen cannula should be put in a plastic bag when not in use and humidifier/bubbler should be changed as needed. On 4/2/2025 at 11:15 AM, V2 (Director of Nursing) stated all oxygen humidifiers need to be changed every 7 days and oxygen appliance should be stored in plastic bag when not in use for infection control. Review of Admission record read: admitted [DATE], Diagnosis Information include CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE; OBSTRUCTIVE SLEEP APNEA; Order Summary indicate Oxygen PRN NC Flow__2__ to Keep Sats Greater Than_ 92% as needed for Low O2 Sat; Care Plan Report indicate Provide oxygen as ordered. Monitor saturation as ordered. Change oxygen tubing, humidifier bottle, oxygen tubing plastic holding bag as ordered. On 4/1/2025 at 11:10 AM, R81 in bed with oxygen per nasal cannula at 4.5 liters per minute. R81 is using a concentrator with attached humidifier dated 3/22/25 and bottle is less than 1/4 filled. On 4/1/2025 at 11:15 AM, V6 (Wound Nurse) checked R81's physician order indicating R81 to have continuous oxygen at 3 liters per minute. V6 stated the oxygen humidifier bottle should be changed as needed. V6 stated humidification is used to keep nasal passages from drying out. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/2025 at 9:40 AM, V2 (Director of Nursing) stated all oxygen humidifiers need to be changed every 7 days and when humidification water level is low, about less than 1/4 filled. Review of Admission record read: admitted [DATE], Diagnosis Information include ACUTE RESPIRATORY FAILURE WITH HYPOXIA; DEPENDENCE ON SUPPLEMENTAL OXYGEN; CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE. Review of Order Summary indicate Oxygen At 3 Liters/Minute Via nasal cannula; Continuously; Care Plan indicate Interventions: Oxygen at 3 Liters/Minute via nasal cannula; Continuously; MDS (Section O - Special Treatments, Procedures, and Programs) indicate Respiratory Treatments C1. Oxygen Therapy while a resident. Policy and Procedure: Title: Oxygen Therapy, no date Policy: It is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care. Procedure: I. Physician Order A. Verify physician's order II. Set-up and administration of oxygen B. Attach the nasal cannula/mask to the oxygen source and turn the flow meter to the ordered flow rate. Policy and Procedure: Title: Equipment Replacement - Disposable - Nursing; Revisions 1/16/18 Purpose: Equipment will be changed following established schedules to prevent contamination. Guidelines: 1. Oxygen/Nebulizer b. Check water levels in humidifier jar every shift and change humidifier jar every 7 days

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39781 Based on observation, interview, and record review the facility failed to lock the medication refrigerator and record the date when medication was opened. This deficiency affects one of two medication storage rooms and one of four medication carts reviewed for Safe medication storage and labeling. Findings include: On 4/1/25 at 9:40AM, Checked second floor medication storage room with V8 RN (Registered Nurse). Observed medication refrigerator unlocked. V8 said that medication refrigerator in the medication room should be locked. On 4/1/25 at 10:22am Checked 3 North medication cart with V11 LPN (Licensed Practical Nurse). Observed R76 's Gentamycin eye drops solution opened but not dated. Observed R18's Combigan 0.2/0.5% eye drop solution opened but not dated. V11 said that medication should be dated when it was opened. On 4/1/25 at 1:15PM, Informed V2 DON (Director of Nursing) of above observation. V2 said that nurses should keep the medication refrigerator locked and they should mark the date when they opened the medication. Facility's policy on Medication storage revision date 7/2/19 indicated: Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes, and needles. Guidelines: 3. General storage procedures: 3.2 Facility should ensure that all medications and biological, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure implementation of appropriate infection prevention and control practices during medication administration including disinfecting of medical equipment use, providing care to a resident on Enhanced Barrier Precaution (EBP), and performing hand hygiene after removing gloves. The facility also failed to place the nebulizer mask and tubing in plastic bag when not in use. This deficiency affects four (R8, R54, F179 and R329) residents in the sample of 25 reviewed for Infection Control Prevention and Control Management. Findings include: On 4/1/25 at 10:57AM, Observed R54 up in wheelchair in his room. R54 is on Enhanced barrier precaution. Observed urinary drainage bag with visible yellow sediments in the tubing hanging over the grab bar next to emesis basin in the bathroom. V11 LPN (Licensed Practical Nurse) said that CNA (Certified Nurse Assistant) change R54's urinary catheter bag to leg bag when he is up in wheelchair. V11 said that emesis basin should not be placed next to the urinary drainage bag. Observed emesis basin is dirty with dried white colored toothpaste inside. On 4/1/25 at 11:35AM, Observed V15 LPN took portable Blood Pressure (BP) machine equipment from another resident in 3 north unit. V15 went to R8 with medication cart and BP equipment. V15 did not disinfect the BP cuff before placing it on R8's left arm and obtained her BP. Informed V15 of observation made. She said BP equipment should be clean/disinfect before and after taking resident's BP. On 4/2/25 at 8:32AM, V19 RN (Registered Nurse) gathered medical equipment for vital signs (portable wrist BP machine, pulse oximeter, and oral thermometer) from her medication cart and prepared medications inside R179's room. R179 is on Enhanced barrier precaution. V19 entered the room without donning appropriate PPE. V19 is wearing mask, she donned gloves when entering the room. She placed the medical equipment for vital signs on bedside tray table. V19 placed the BP wrist on R179's left wrist, then placed the pulse oximeter on left index finger and took oral temperature. After obtaining vital signs, she then administered prepared medications. She brought her medical equipment on top of the medication cart. She wiped the medical equipment with disinfectant wipes. On 4/2/25 at 8:50AM, Informed above observation with V19 RN and V17 Restorative Nurse. V19 said that she did not don gown because she was just taking vital signs and performing oral administration of medication. V17 Restorative Nurse said that appropriate PPE is observed during medication administration and taking vital signs in EBP. V17 said that they should follow manufacturer recommendation in using disinfecting wipes which is contact time of disinfectant of 3 minutes. On 4/2/25 at 11:01AM, Informed V3 Infection Preventionist of above observation. V3 said that vital signs equipment is only disinfected after using and not before. V3 said that no need to don PPE when taking vital signs and medication administration to resident on EBP. V3 said that disinfectant wipes manufacturer recommended keeping wet for 3 minutes. V3 said that emesis basin should not be placed next to urinary drainage bag in the bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 11:16AM, Informed V2 DON (Director of Nursing) of above observation. V2 said that they should disinfect medical equipment for taking resident vital signs before and after using. V2 said that they should don appropriate PPE when taking vital signs and administration of medications to resident on EBP. V2 said that they should not place emesis basis next to urinary drainage bag in the resident's bathroom. They placed order in resident's chart for resident on transmission-based precaution including EBP. On 4/3/25 at 9:40AM, Review R8's medical record with V3 Infection Preventionist. Informed V3 that R8 does not have order for Enhanced Barrier Precaution. R8 has colostomy and receiving Triamcinolone Acetonide cream treatment for itching to upper back, BUE, shoulder and BLE. R8 has red rashes on her upper extremities. Facility's policy on Enhanced Barrier Precaution (EBP) revision 4/1/24 indicated: Purpose: To minimize the risk of acquiring, transmitting, or complications resulting from multi-drug resistant organism (MDRO) colonization among residents in this setting. (Contact precautions would be warranted over EBP when there is risk of transmission of an actively infectious agent) Guidelines: *Residents will require the use of personal protective equipment (PPE) for high-risk activities such as: -Any situation where expected contact of blood, bodily fluids, skin breakdown, or mucous membrane will be encountered. *PPE required: -Gown -Gloves *Persons expected to encounter these circumstances are to don PPE (gown and gloves) in accordance with the activity that will be encountered when caring for the resident. Facility's policy on Cleaning & Sanitizing- wheelchairs and other medical equipment revision 1/25/18 indicated: Purpose: To assure that devices are cleaned and sanitized on a regular or as needed basis. Guidelines: 5. Devices/equipment used for more than one resident shall be cleaned between each resident. Manufacturer's recommendation for Germicidal bleach wipes (surface cleaning chemicals and disinfectants) indicated: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Overall contact time of 3 minutes. Contact time for a disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection. 49871 On 4/1/2025 at 10:55 AM, V4 (Director of Guest Relation) removed and discarded his gloves then proceeded to resident room [ROOM NUMBER] without performing hand hygiene. On 4/1/2025 at 10:56 AM, V4 stated he performed hand hygiene before putting gloves on but not after removing it. V3 (Infection Control Nurse) said hand hygiene should be performed before and after removing gloves. On 4/2/2025 at 9:40 AM, V2 (Director of Nursing) said hand hygiene should be done after removing gloves and if hands are visibly soiled then hand washing with soap and water need to be performed. On 4/1/2025 at 11:00 AM, R329 seated on the wheelchair said she gets breathing treatments. Nebulizer treatment machine on top of the nightstand table with mask and tubing attached to the machine. On 4/1/2025 at 11:02 AM, V3 (Infection Control Nurse) said nebulizer kit, mask and tubing, should be kept in a ziplock/plastic bag for privacy. Mask should be rinse and air dry after each used. On 4/2/2025 at 9:40 AM, V2 said nebulizer mask and tubing should be kept in a ziplock bag when not in used for infection control. Nebulizer mask should be rinsed and air dry after each used. Review of Admission record read: admitted [DATE], Diagnosis Information include PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT; Order Summary indicate Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 dose inhale orally every 6 hours for SOB while awake. Care Plan Report indicate Administer respiratory treatment (Ipratropium-Albuterol) as ordered. Policy and Procedure Title: Hand Hygiene/Handwashing, Revisions: 1-10-18 Definition: Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). Guidelines: When to Wash Hands With Soap and Water ONLY (may use Alcohol Based Hand Sanitizer for All Other): After glove removal Policy and Procedure Title: Oral Inhalation Administration, Date: 10/25/2014 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145683	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Abington	3901 Glenview Road Glenview, IL 60025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: To allow for safe, accurate, and effective administration of medication using an oral inhaler (with or without a spacer/chamber) or nebulizer. Nebulizer - Administering Medications through a Small Volume (Handheld) Nebulizer U. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or: 1. Wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel. W. When equipment is completely dry, store in a plastic bag with resident's name and date on it.