

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2024
NAME OF PROVIDER OR SUPPLIER  Elevate Care Palos Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  12550 South Ridgeland Avenue Palos Heights, IL 60463	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44570</p> <p>Based on interview and record review, the facility failed to maintain a record of controlled substances proof of use accounting for each dose of narcotic medications given and disposed. This failure affected 15 of 15 residents (R6-R21) who were reviewed for disposition of controlled drugs.</p> <p>Findings include:</p> <p>This survey was conducted on-site in the facility from [DATE] to [DATE].</p> <p>On [DATE] at 2:43pm V2 Director of Nursing and V3 Nursing Supervisor were interviewed regarding reconciliation and destruction of controlled medications. V3 and V4 said that they, along with V4 Assistant Director of Nursing were responsible for disposing controlled medications that were discontinued or not sent home with the residents. V3 said that they were unable to provide documentation in any of the resident's health record that accounted for each dose of controlled medication used and/or disposed. V3 said that once the medications were disposed under witness, the individual Resident Controlled Drug Receipt/Record/Disposition Form was disposed in the shredder and not uploaded into the electronic record. V3 was unable to provide explanation for this practice or how discrepancies were able to be reviewed without the sheet accounting for each dose.</p> <p>On [DATE] at 9:37AM V1 Administrator said that the facility did not have a policy stating that the forms needed to be preserved in the resident records.</p> <p>During this investigation, the facility provided two versions of forms used by nursing staff to record use of controlled substance medications: Controlled Substances Proof of Use and Controlled Drug Receipt/Record/Disposition Form. Both forms state which both state in part: Every dose must be accounted for.</p> <p>Facility policy titled Medication/Narcotic Destruction revised ,d+[DATE] states in part: 8. The drug disposition record must contain, as a minimum, the following: a. Resident's name, b. Date drug destroyed, c. Name of drug, d. Strength of drug, e. Prescription number, f. Quantity destroyed, g. Method of destruction, h. Signatures of witnesses.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at approximately 3:00pm V2 Director of Nursing provided Drug Disposition Records from [DATE], [DATE] and [DATE]. These forms provided by V2 did not include the method of destruction as stated in the policy. V2 said that the forms were kept for their own records in the office and said the form was personally taken from the Internet. V2 said they were unaware that the disposal of medications should be reflected on the resident's individual record which is accompanied with the medication supplied by the pharmacy.</p> <p>The following are the residents reviewed for not having a complete accounting for each dose of controlled medications:</p> <p>R6 admitted to the facility on [DATE] and discharged [DATE]. Active medications at the time of discharge included hydrocodone/acetaminophen ,d+[DATE]mg (milligrams), Pregabalin 75mg and alprazolam 1mg. V3 documented disposal on [DATE] of seven tablets (tabs) of pregabalin, 11 tabs of hydrocodone/acetaminophen ,d+[DATE]mg, and 14 tabs of alprazolam.</p> <p>R7 admitted to the facility [DATE] and discharged [DATE]. Active medications at the time of discharge included oxycodone/acetaminophen ,d+[DATE]mg. V3 recorded four tablets were disposed on [DATE].</p> <p>R8 was admitted [DATE] and discharged [DATE]. Active medications at the time of discharge included acetaminophen/Codeine ,d+[DATE]mg, clonazepam 0.5mg and hydrocodone/acetaminophen ,d+[DATE]mg. V3 documented disposal on [DATE] of 30 tabs of hydrocodone/acetaminophen, 19 tabs of acetaminophen/codeine and 10 tabs of clonazepam.</p> <p>R9 was admitted [DATE] and discharged [DATE]. Active medications at the time of discharge included hydrocodone/acetaminophen ,d+[DATE]mg. V3 documented disposal on [DATE] of 26 tablets.</p> <p>R10 was admitted [DATE] and still resides in the facility at this time. Physician order sheet includes clonazepam 0.5mg ordered [DATE] and discontinued [DATE]. V3 documented disposal of 30 tabs on a Drug disposition record dated [DATE].</p> <p>R11 was admitted [DATE] and still resides in the facility. Physician Order Sheet includes an active order for tramadol 50mg. According to R11's orders, tramadol was discontinued [DATE] due to R11 being hospitalized and the order was reinstated upon return to the facility on [DATE]. V3 documented 29 tabs of tramadol 50mg disposed on [DATE].</p> <p>R12 was admitted [DATE] and expired in the facility with hospice services on [DATE]. Active orders at the time of expiration included lorazepam 2mg/ml (milliliter) dispensed as 30ml bottle. This medication was ordered [DATE] and discontinued [DATE]. Alprazolam 0.25mg tablets ordered [DATE] and discontinued [DATE]. Other orders active at the time of discharge included morphine sulfate oral solution 20mg/5ml dispensed as 30ml bottle and hydrocodone/acetaminophen ,d+[DATE]mg tables. V3 documented on [DATE] disposition record: morphine 100mg/5ml 29ml (disposed), morphine 100mg/5ml 22ml (disposed) as well as alprazolam 0.25mg three tablets, hydrocodone/acetaminophen ,d+[DATE]mg 29 tabs, lorazepam 2mg/ml-22ml (disposed).</p> <p>R13 was admitted [DATE] and still resides in the facility. Physician's order sheet includes an original order for hydrocodone/acetaminophen ,d+[DATE]mg as needed for pain on [DATE]. R13 was admitted to the hospital on [DATE] and returned to the facility [DATE] with an order to reinstate the medication. V3 documented disposal of 3 tabs of hydrocodone/acetaminophen ,d+[DATE]mg on [DATE].</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 - Some</p>	<p>R14 admitted to the facility [DATE], discharged to the hospital [DATE] and did not return. Physician's order sheet included tramadol 50mg ordered [DATE] and discontinued [DATE]. V3 documented 28 tabs disposed on [DATE].</p> <p>R15 admitted to the facility [DATE] and discharged [DATE]. Physician order sheet included zolpidem ER (extended release) 12.5mg tablet. V3 documented disposal of six tablets of zolpidem 12.5mg on [DATE]. V3 also documented zolpidem 10mg five tabs disposed for R15, however this order history could not be identified on the Physician's Order Sheet.</p> <p>R16 was [DATE] and still resides in the facility. Physicians order sheet indicates that hydrocodone Acetaminophen ,d+[DATE]mg was ordered [DATE] and discontinued when R16 was hospitalized on [DATE]. The medication was reinstated on return to the facility [DATE]. V3 documented disposal of 11 tablets [DATE].</p> <p>R17 admitted to the facility [DATE] and discharged [DATE]. Physician Orders at the time of discharge included hydrocodone acetaminophen ,d+[DATE]mg tablets and morphine sulfate 30mg tablet. No Proof of use forms were identified in the electronic health record. V3 documented disposal of morphine 30mg six tablets on [DATE]. No documentation was provided for acetaminophen ,d+[DATE]mg tablets.</p> <p>R18 was admitted to the facility [DATE] and discharged to sister facility [DATE]. Physician's Order Sheet at the time of discharge included tramadol hydrochloride 50mg tablet ordered [DATE]. This medication was discontinued [DATE], three weeks after R18 was discharged from the facility. V3 documented disposal of 19 tramadol 50mg tabs on [DATE].</p> <p>R19 admitted to the facility [DATE] and discharged [DATE] to a long-term care facility. Physician's Order Sheet at the time of discharge included order for Hydrocodone-Acetaminophen ,d+[DATE]mg. V3 documented disposal of 22 tablets on [DATE].</p> <p>R20 admitted to the facility and still resides in the facility. On [DATE], V3 documented disposing six tablets of alprazolam 0.5mg tablets. Physician's Order Sheet reviewed indicated that alprazolam 0.5mg was an active order at the time of disposition, and the control proof of use is not available to review for reconciliation.</p> <p>R21 admitted to the facility [DATE] and still resides in the facility. Physician's order sheet reviewed , d+[DATE] indicates that tramadol 50mg was originally ordered [DATE] and continues to be an active medication. On [DATE], V3 documented disposition of two tramadol 50mg medicine cards- 30 tablets on one and 10 tablets on another.</p> <p>On [DATE] at 10:05AM V5 Pharmacist said the nurses are expected to document the count of each medication using the count sheet that is accompanied with the medication dispensed. The expectation of the facility is that they are responsible for maintaining and carrying out their own policy for destruction of controlled substances.</p> <p>[DATE] at 10:22AM V6 Medical Director said the nurses should be accounting for each pill on the count form and the Medication Administration Record. This form should be a part of the Resident's medical record so that it could be referenced in the future for review such as now.</p>		