STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Country Club Hill	18200 South Cicero Avenue Country Club Hills, IL 60478

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** 22499 Based on interview and record review the facility failed to identify and treat pressure ulcers for a resident dependent on staff for care. This affected one of three residents (R4) reviewed for pressure ulcers. This failure resulted in R4's pressure ulcers not being found/treated until they were an advanced stage on 10/17/23, 3/21/24 and 4/11/24. The findings include: R4's face sheet printed on 5/24/24 shows that R4 was admitted to the facility on [DATE] with diagnoses including Anoxic Brain Damage, Acute and Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Dependence on Ventilator, End Stage Renal Disease, Dependence on Renal Dialysis, and history of Sudden Cardiac Arrest. R4 was discharged from the facility on 4/29/24 to the hospital and was not in the facility on 5/24/24. R4's Shower Form dated 10/17/23 shows that R4 has skin tears to her sacrum, posterior right thigh, and right ear. A handwritten comment on this form states, open areas noted. R4's Wound assessment dated [DATE] shows that R4 developed a facility acquired Deep Tissue Injury measuring 7 x 8 x Unknown cm that was 90% deep maroon in color and 10% pink or red non-granulating tissue. (R4 was last readmitted to the facility from the hospital on 9/11/23) R4's Initial Wound Physician Progress Note dated 10/20/23 states, Wound #1 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss pressure ulcer and has received a status of not healed. Initial wound encounter measurements are 6 cm length x 4 cm width x 0.1 cm depth . There is a light amount of serosanguineous drainage noted which has no odor. Wound bed has no granulation, 100% slough . On 5/24/24 the facility provided two Shower Forms both dated 3/21/24. The first form shows that R4 has four open areas, sacrum, left elbow, right heel, and left heel. This form also shows that R4 has a G-tube (Gastrostomy). This form is signed by a CNA and a nurse. The second Shower Form is dated 3/21/24 and shows that R4 has an open area on her right elbow and is signed only by a nurse. (continued on next page)

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

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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	R4's Wound assessment dated [DATE] shows that R4 developed a facility acquired Unstageable wound to her left elbow measuring 1 x 1.5 x Unknown cm that is described as 50% bright pink or red and 50% necrotic soft, adherent. R4's Wound Physician Progress Note dated 3/22/24 does not address R4's left elbow. R4's Wound Physician Progress Note dated 3/29/24 states, Left elbow is a stage 3 Pressure Ulcer and has received a status of Not Healed. Initial Wound encounter measurements are 1 cm length x 1 cm width x 0.1 cm depth .There is a light amount of serous drainage noted which has no odor. R4's Treatment Administration Record shows the first treatment was applied to R4's left elbow on 3/23/24. (Wound found on 3/21/24) On 5/24/24 the facility provided two Shower Forms both dated 4/11/24. The first form shows that R4 has seven open areas (none on her right lateral foot), a Tracheostomy/trach and a Gastrostomy/Gtube. This form is signed by a CNA and a nurse. The second Shower Form also dated 4/11/24 shows that R4 has only one open area on her right lateral foot This form is signed only by a nurse. R4's Wound assessment dated [DATE] shows that R4 developed a facility acquired Deep Tissue Injury measuring 2.1 x 1.8 x unknown cm. The wound is described as a 100% blood filled blister. R4's Specialty Wound Evaluation and Management Summary dated 4/22/24 shows that R4 has an Unstageable DTI (Deep Tissue Injury) measuring 1.7 x 1.5 x Not measurable cm to her right lateral foot. The wound is described as intact with purple/maroon discoloration. On 5/24/24 at 11:40 AM V17 (LPN- Wound Care Nurse) stated that R4 had 5 pressure sites at the time of her discharge. V17 stated, We do our own assessment and then we contact the wound care physician. It would be expected that the staff notify us before seeing the wound becoming a deep tissue injury. The sacral wound, the left elbow and the right lateral foot were all found during treatment of other wounds by a treatment nurse. (R4) did not move at all and she had contractures. Our skin assessments are done 2x/times a week during the showers the CNAs have the nurse come and do a skin check. R4's Care Plan Initiated on 6/30/23 states, (R4) has active skin issues and remains at high risk for further skin breakdown related to her diagnosis of anoxic brain damage, respiratory failure, End stage renal disease with dependency on dialysis, diabetes, dependency on trach and Gtube, immobility, total dependence. The interventions for this focus include Document: if skin is intact. If skin is reddened or has open areas. Report any new openings to Registered Staff.