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	11/22/2024

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 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** 39781 Based on interview and record review the facility failed to ensure resident safety by failure to provide two persons assist to a totally dependent resident (R121) when providing incontinence care. This failure resulted R121 falling from bed that required a visit to the hospital for evaluation and repair of a laceration to the scalp which needed three staples. This deficiency affects one (R121) of three residents in the sample of 32 reviewed for Resident safety/Fall Prevention Program. Findings include: On 11/20/24 at 10:03AM, V30 Family member stated the facility failed to provide adequate care and supervision causing R121 to fall while receiving care. R121 fell from bed resulting in a head laceration. R121 legs are contracted and laid still. On 11/20/24 at 10:30AM, V1 Administrator and V2 Director of Nursing (DON) stated that R121 fell from bed on 11/4/24 during incontinence care provided by V29 Certified Nursing Assistant (CNA). On 11/20/24 at 10:48AM, R121 lying in bed with low air loss mattress. She (R121) is nonverbal. R121 has a Tracheostomy connected to oxygen at 3LPM (liters per minute). R121 has Gastrostomy tube connected to Glucerna 1.2 feeding tube at 65ml/hour. She is totally dependent of ADLs (Activity in Daily Living) and transfers. Review of R121's incident report submitted to the State Agency on 11/5/24 indicated: Date of incident: 11/4/24 at 6:30AM. Witnessed fall with physical harm or injury. V29 CNA written statement indicated she was providing ADL care to resident. As she rolled R121 over to provide incontinence care she began to slide out of the bed. She called for assistance from V25 LPN (Licensed Practical Nurse). Observed R121 on the floor in a side lying position. Noted moderate blood to the posterior scalp. Bleeding controlled. No loss of consciousness (LOC) noted. Neuro check initiated with no deviation from baseline. ROM (range of motion) done to all extremities and were within normal limit. Physician made aware and ordered to send R121 to hospital for evaluation. V30 Family member notified. R121 returned to facility with three staples to right lateral head. (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 - Actual harm Residents Affected - Few	R121's hospital records dated 11/4/24 indicated: Witnessed fall from her bed and hitting her head. Per EMS (Emergency medical services), staff reports that the R121 was being cleaned up by staff and she rolled off her bed. Staff reports R121 has no LOC and has laceration to the head. R121 non-verbal at baseline. Clinical impression: Laceration of scalp, Fall. Physical exam: 2 cm laceration to the right sided parietal scalp without active bleeding or surrounding erythema. Laceration repair: three staples to right parietal scalp. R121 is readmitted on [DATE] with diagnoses listed in part but not limited to Anoxic brain damage, Chronic respiratory failure with Hypoxia, Tracheostomy, Gastrostomy, Dysphagia. Comprehensive care plan indicates she has an ADL self-care performance deficit related to disease process of anoxic brain damage, dependent for ADLs and mobility, incontinent of bowel and bladder. She has contractures to all extremities. She is at risk for falls and fall related injuries related to decreased mobility and impaired balance. Most recent MDS/Resident assessment dated [DATE] section GG Functional abilities: GG0130 Self-care indicated: Toileting hygiene, Shower/bathe self and Personal hygiene coded as 01-Dependent- helper does all of the effort, Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. GG0170 Mobility indicated: Roll left and right coded as 01-Dependent- helper does all of the effort, Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. On 11/20/24 at 1:48PM, V1 Administrator stated that they don't have policy on Resident safety. On 11/21/24 at 10:22AM, V25 LPN stated he was working with R121 when she had the fall incident while V29 CNA was providing incontinence care. V25 stated that R121 is totally dependent in ADLs and needed two person assist with mechanical lift transfers. V25 stated that he did not witness the fall incident. V25 stated that V29 CNA should have pulled R121 toward her or closer to her instead of rolling R121 away from her for safety. On 11/21/24 at 10:49AM, V26 Nursing Supervisor 11-7 shift stated she was called by V25 LPN to R121's room. V26 stated, she observed R121 in a lying position and observed laceration to scalp. V26 stated they controlled the bleeding. Physician and family were notified of the incident. R121 was sent to the hospital for evaluation. R121 returned with staples to the lacerated scalp. V26 stated that they did in-service the nursing staff of proper position/transition during incontinence care. V26 stated that for resident safety, CNA should get assistance of two persons to assist dependent resident for incontinence/ADL care. V29 CNA should pull R121 towards/ closer to her to prevent R121 slipping from edge of the bed. On 11/21/24 at 11:23AM, V29 CNA stated that she was providing incontinence care with R121, when she slid off the bed. V29 stated that she should have pulled R121 towards/closer to her instead of rolled her away from her placing her at edge of the bed. On 11/21/24 at 12:02PM, V27 MDS/Restorative Nurse stated that she did the MDS/Resident assessment of R121. V27 stated R121 is totally dependent with ADLs and transfers. Section GG functional abilities indicated that she needs two assists with bed mobility- roll to left and right side and personal hygiene and grooming. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/21/24 at 1:20PM, V2 DON stated that they did in-service the nursing staff regarding proper and safe positioning and bed mobility to dependent resident such as ensuring that there is as adequate number of caregivers present to safely position or move the patient. V2 stated, when providing ADLs/incontinence care in bed that staff should roll/pull the resident toward /closer to them to prevent placing resident at the edge of the bed and avoid slipping out of bed. Facility unable to provide policy on Resident Safety. Facility's policy on Fall Prevention Program revision 11/21/17 indicates: 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. Facility's tips for positioning a patient in bed: The process of positioning a patient in bed should be smooth, safe, and comfortable for both the caregiver and patient. * Ensure that there is an adequate number of care givers present to safely position or move the patient.