STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Windsor Park	2649 East 75th St Chicago, IL 60649

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** 45110 Based on interview and record review, the facility failed to implement their fall prevention policy to ensure the safety of a resident by failing to assess for the risk for falls and implement appropriate fall prevention interventions. The facility also failed to provide supervision and assistive devices to utilize as necessary for one of three residents (R1) reviewed for falls. These failures resulted in R1 falling, requiring transport to the local emergency department where R1 was diagnosed with a closed fracture of the neck of the left femur, requiring surgical repair. Findings include: R1's clinical record indicates R1's medical diagnoses including epilepsy, history of falling, essential hypertension, dementia, psychotic disorder with delusions, elevated prostate, disorder of the kidney and ureter, and schizophrenia. R1's Minimum Date Set [MDS] section [C] dated 11/25/24 indicates R1 is severely cognitively impaired. R1's fall assessment indicates R1 is a high fall risk. R1's Lab: 11/25/24 phenytoin level = 23.2 [high level] the range is [10-20] valproic acid level = 35.4 [low] the range is [50-100] R1 hospital document dated 11/25 indicates in part: R1 admitting diagnosis of mechanical fall, closed fracture of neck of left femur. (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	R1's concise hospital course: R1 arrived to the emergency department from the facility due to a mechanical fall on 11/25/2024. Per nursing home staff R1 was in dining room when he got up to stand and walk. He then fell landing on his left side. R1 begin endorsing severe pain with movement of the left foot leg after the fall on 11/25/24. X-rays were obtained of R1's bilateral hips, legs and knees and showed an acute left femoral neck fracture. Additional work up revealed supratherapeutic phenytoin level likely cause gait instability resulting in mechanical fall and urinary tract infection. Workup was negative for metabolic sources of encephalopathy, cardiogenic and neurogenic causes of syncope. Hip fracture treated with hemiarthroplasty on 11/27/24. R1's urinary tract infection was treated with intravenous antibiotics. R1's supratherapeutic phenytoin treated with the discontinue of medication and was replaced with Keppra (anti-convulsant). R1's hospital course complicated by post op hematoma of prostate posterior left hip. Orthopedic surgery recommended no reoperation in setting of risk of additional bleeding. R1's care plan documents the following: 9/2/24- R1 is to be up and in close proximity of staff attending to him d/t (due to) his impulsiveness to get up and wander around aimlessly. R1 is ambulatory but at times his gait can get unsteady. Labs were also ordered to rule out any abnormalities. 11/25/24- Staff were re-educated on the importance of being within close proximity of R1 due to his impulsiveness to get up and wander around aimlessly. R1 is ambulatory with supervision, touching assist but at times gait can be unsteady due to multiple contributing factors. Labs were previously ordered on this day. Findings were abnormal valproic acid level as well as abnormal phenytoin level which could have possibly contributed to the R1's unsteady gait. R1 was also sent out to hospital for x-ray of left hip due to complaints of pain. Staff will follow post-discharge medication regimen upon return to facility. R1 was also referred to therapy for gait/balance re-training. Fall mat on right side of bed also implemented to decrease chance of further injury. R1 also with 1:1 supervision as precautionary measure due to R1's impulsiveness to get up and walk unassisted. R1's progress note documented in part: 11/25/2024 17:12 V8 [Nurse Practitioner] Progress Notes Note Text: labs viewed for 11/25/24. Okay for nurse to clear labs. New orders to hold Phenytoin/Dilantin and increase in dosage for Divalproex BID. Plus, one-time extra dose of divalproex for low level. Nurse to confirm orders in PCC. 11/25/2024 21:36 Nurses Notes V7 [Licensed Practical Nurse] Note Text: R1 in the dining room with staff, patient attempted to stand and lost balance, falling on the left side. Assessed the patient, during assessment the patient expressed verbal pain to the left side. Staff stated R1 did not lose consciousness or hit his head. V8 [Nurse Practitioner] notified and received stat orders for pain management and to send the patient to the hospital. V3 [R1's Family Member] notified, voiced concerns, requesting a call from management. R1 left facility via ambulance. Interviews: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/7/24 at 10:20 AM, V3 [R1's Family Member] stated, On 11/25/24, the nursing staff called me and told me he was in the dining room, tried to stand up but lost his balance and fell on his left side. The first question I asked was how R1's phenytoin was and valproic acid levels. The nurse told me the phenytoin was 23.2 which is high and valproic acid level was 35.4 which was low. R1 was sent to the hospital because he complained of pain in his left hip. During R1's visit in the emergency department, the physician told me that R1's phenytoin level was like 32 which is high and valproic acid was low would make R1 weak, unbalance, unstable and disorientated that contributed to R1's fall, which led to a fracture left hip. Normally R1 was able to go from sit to stand and ambulate without any assistance or assistive devices. The nurse knew his level was high and she continued to give him the medication anyways, because his level in the hospital was much higher. The nursing staff know when his levels are not right, he will fall. The same situation happened in September; R1 fell but did not hurt himself. The director of nursing told me the nursing staff is aware that when R1's levels are not therapeutic, R1 is at a very high risk to fall and to monitor him closely. On 12/7/24 at 10:50 AM, R1 was resting in bed low to the floor, with a mat on the floor, call light in reach with a staff member at bedside. V9 [Certified Nurse Assistant] stated, I been sitting with R1, providing one to one assistance and monitoring. R1 has been resting and receiving pain medication as needed. On 12/7/24 at 1:40 PM V6 [Certified Nurse Assistant] stated, I was R1's certified nurse assistant on 11/25/24. I witnessed R1's fall. After dinner around 8:45 PM, R1 was in the dining room sitting in a chair, when he tried to stand up, lost his balance and fell . R1 was not in a wheelchair. I got the nurse [V7 Licensed Practical Nurse] to assess him. R1 did not complain of pain until we tried to put him in the bed. I was not made aware R1's seizure medication was abnormal, and he gait would be unsteady. After dinner other nursing certified aides was walking in and out the dining room toileting residents and assisting them to bed. I was not monitoring R1 continuous. When I entered back in the dining room, I saw the fall. On 12/8/24 at 9:05 AM V7 [Licensed Practical Nurse] stated, I been working here for thirteen years. I been taking care of R1 since his admission several years ago. I am familiar with R1. I was R1's nurse on 11/25/24. The start of my shift I noticed R1 was more confused and was not acting like himself. I know he usually act like this when his antiseizure medication levels are out of range. I notified V8 [Nurse Practitioner], and received an order for a phenytoin, and valproic acid level. I placed in the lab order and notified the lab. I continued with my morning medication pass. The lab came and took R1's blood, later R1 received all his medications. I worked a double shift on 11/25, later around 5 PM, I received his lab results. R1's phenytoin level was 23.2 [high level] the range is [10-20], valproic acid level was 35.4 [low] the range is [50-100]. I notified V8 and received an order to hold R1's evening dose of phenytoin and to increase R1's Depakote. After dinner around 9PM, R1 was sitting in the dining room when V6 observed him try to stand up from the chair, lost his balance and fell before she could reach him. I was in another resident's room when I heard R1 fall, I ran right in to assist. There was other residents and nursing staff going in and out the dining room taking residents to their room to change them and helping them to bed. I know when R1's phenytoin and Depakote levels are not in the correct range it makes R1 wobbly and more confused, which I noticed at the start of my shift. When R1 fell , I assessed him, and the nursing staff and I assisted R1, and he did not complain of pain. When we tried to help him in bed, R1 complained of pain in his left leg. I phoned V8 and received an order to send R1 to the hospital. I'm not sure if I told V6 to monitor R1 closely because his blood levels were abnormal. It was around dinner time, and everyone was busy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/7/24 at 11:10 AM V10 [Licensed Practical Nurse] stated, I am R1's nurse today and familiar with R1. Since his fall he been in bed resting with a one-to-one sitter. V8 monitors R1 blood levels for his seizure medications. I know that when R1's seizure medication is high or low it makes R1 gait unsteady and needs close monitoring. On 12/7/24 at 2:10 PM, V5 [Director of Restorative/Registered Nurse] stated, I assist with fall investigations and develop an individualized care plan related to each fall, to prevent another fall from occurring. Prior to R1's fall he was able to go from sitting position to standing up alone without any assistance. R1 ambulated with a steady gait without any assistance from staff nor any assistive devices. On 9/2/24 R1 had a fall, when labs findings were abnormally low valproic acid level, which could have contributed to R1's fall. When valproic acid levels are low, that causes the resident to become weak and to have an unsteady gait. The interventions for 9/2/24 fall was for R1 to be up and in close proximity of staff attending to him due his impulsiveness to get up and wander around aimlessly. On 11/25/24, R1 was in the dining room after dinner around 8:30 PM, R1 went to stand up, lost his balance and fell . Interventions: staff was re-educated on importance of being within close proximity of R1 due to his impulsiveness. R1 is ambulatory but needs supervision, and at times his gait can be unstable due to his valproic acid levels and phenytoin levels were abnormal which could contribute to R1's fall. Now R1 is one -to one monitoring with low bed with mats. The nursing staff was made aware of R1's fall interventions for 9/2/24. R1 has been a resident here for some years. It's known that when his antiseizure medication levels are abnormal, R1 is at high risk to fall. R1's nurse should have monitored R1 closely and had him near her at the nursing station and provided R1 with a wheelchair due to his unsteady gait. On 12/7/24 at 3:38 PM V4 [Assistant Director of Nursing] stated, I reviewed R1's fall care plan. I seen R1 fell on [DATE] due to his seizure medication not being in therapeutic range. Whenever anyone's Depakote or phenytoin levels are not in therapeutic range it causes weakness, and unsteadiness. R1's plan of care indicates when R1's levels are not normal to monitor R1 closely. After dining the certified nurse assistances are taking residents out of the dining room, providing incontinent care can assisting residents to bed. R1's fall was avoidable, once V7 was made aware of R1's abnormal labs, V7 should have told R1's certified nurse assistant [V6], to monitor R1 very close. While the certified nurse assistants were busy providing care, V7 should've had R1 at the nursing station with her for close monitoring. Since R1's return, he has a sitter in his room to provide one to one monitoring. On 12/9/24 at 12:22 PM, V8 [Nurse Practitioner] stated, R1 is normally able to ambulate without assistance or the use of any assistive devices. The nurse [V7] made me aware that R1 was unsteady, and he was more confused than usual. I ordered Depakote and phenytoin levels. I reviewed R1's labs and ordered to hold R1's phenytoin for the next three days until 11/27/27 at 3PM. Re-start phenytoin on 11/27 at 5PM dose. I increase R1's Depakote dose I received a phone call that R1 had tried to stand up, lost his balance and fell on his left side. R1 became guarded on his left leg. I ordered state x-rays for R1, but the x-ray company could not come out. So, then I gave the order to sent R1 to the hospital for further evaluation. Policy documents in part: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall prevention program dated 11/28/12 to assure the safety of all residents in the facility when possible. The program would include measures which determine the individual needs of each resident by assessing the risk of falls and implementing of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The fall prevention program uses and implements of professional standards of practice, and communication with direct care staff members, save the interventions will be implemented for each residence identified at risk, direct care staff will be orientated and trained in the fall prevention program. Licensed Practical Nurse job description: Direct the day-to-day functions of the nursing assistants. Provide leadership to nursing personnel assigned to your unit and ship. Monitor your assigned personnel to ensure they are following established safety regulations.