| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145970 | A. Building<br>B. Wing | 06/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Elevate Care Windsor Park | 2649 East 75th St<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide wound care treatment and change wound dressing as ordered by physician to one (R1) resident identified as a high risk for development of pressure ulcer. This failure affected one (R1) out of three residents reviewed for improper nursing care. As a result of this failure, R1 had worsening/deterioration and infection of pressure ulcer.<br><br>The findings include:<br><br>R1's admission record showed admission date of 5/12/2025 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, Essential (primary) hypertension, Aphasia following cerebral infarction, Dysphagia following cerebral infarction, Acute respiratory failure with hypoxia, Pneumonitis due to inhalation of food and vomit, Encounter for attention to gastrostomy, Pressure ulcer of sacral region unstageable.<br><br>R1's MDS (Minimum Data Set) dated 5/20/2025 showed R1 was rarely or never understood. R1 needed total assistance or dependent with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer. Always incontinent of bowel and bladder. MDS showed unstageable pressure ulcer that was present upon admission.<br><br>R1's risk assessment/Braden Score was assessed on 5/14/25, 5/26/25, 6/2/25 and 6/11/25 and documented as 12 (high risk for acquiring pressure wounds).<br><br>On 6/22/25 at 11:18AM Wound care observation conducted with V4 (Wound Care Director, Registered Nurse/RN) assisted by V8 (Restorative Aide, Certified Nursing Assistant/CNA). R1 was observed lying in bed, alert but nonverbal with enteral feeding infusing. R1 observed with wound dressing to sacral area dated 6/18/25, soaked with yellowish and some pinkish discharges. V4 stated wound dressing was dated 6/18/25 and the wound treatment order is daily. V4 said R1 has an unstageable pressure ulcer to sacrum extending to the buttocks. Observed wound bed pinkish with yellowish slough. V4 cleansed the wound with normal saline and pat dry with gauze. V4 applied skin prep on surrounding wound area. V4 applied Gentamycin ointment to wound bed then Santyl ointment to slough area and metronidazole cream to surrounding area prevent contamination per V4 then covered with dry gauze and foam dressing and dated 6/22/25.<br><br>(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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 6/22/25 at 11:54AM V24 (Inhouse Nurse Practitioner/NP) stated she is following R1 and aware of the sacral wound and the wound care team is following/evaluating it. V24 stated there was a concern of wound infection so a wound culture was taken, and the result came out yesterday and read as positive for Proteus Mirabilis, A. Baumanii, CRE (Carbapenem-resistant Enterobacteriaceae). V24 stated R1 is currently on antibiotic treatment for wound infection. V24 said as a standard nursing practice, the wound dressing is dated when the dressing is changed to know when it was done or for communication purposes. She stated if the wound treatment or dressing is not changed as ordered it could potentially cause infection or wound deterioration.<br><br>On 6/22/25 At 1:03pm V4 (Wound Care Director, RN) stated she has been working in the facility for almost a year. She stated the Wound MD (medical doctor) or NP is coming to facility weekly to follow up/evaluate resident's wound/pressure ulcer. V4 said wound treatments should be done and dressing should be changed as ordered by physician. She said the dressing is dated on the day of the treatment to know when it was done. V4 stated it is the facility's policy that the wound dressing should be dated. She said all treatment orders should be done and sign in the TAR (treatment administration record) once treatment was provided. V4 said nursing standard of practice when it was not signed, it was not done. She said when wound treatment was not done or dressing was not changed as ordered, potentially it can lead to decline or worsening of wound or infection. R1's EHR (electronic heath record) reviewed with V4 and stated R1's was admitted with unstageable pressure ulcer to sacrum, measured 2 x 1.3cm x unknown depth. V4 said on 5/27/25 sacrum pressure wound extended to the right buttock. On 6/17/25 wound assessment: Unstageable to sacrum extending to the right buttock, measurement: 8 x 8 cm x unknown. V4 said wound has worsened or declined due to increase of wound size. She said wound treatment order is Santyl and gentamicin to necrotic tissue, metronidazole cream for contamination and zinc to peri area then cover with dry dressing daily. V4 said sacral wound was observed getting bigger in size and ordered for wound culture. She said wound culture result dated 6/21/25 showed light growth proteus mirabilis and light growth CRE. V4 said R1 is on oral antibiotic for wound infection. V4 stated R1 has an order for moisture barrier cream with zinc to protect skin and prevent further breakout.<br><br>On 6/22/25 At 2:54PM V2 (Director of Nursing/DON) stated he has been working in the facility for over a year now. He said staff is expected to do wound treatment and changed dressing as ordered. He said wound dressings should be dated on the day that it was done. V2 said moisture barrier cream with zinc oxide if it is ordered for the resident, should be done and signed in TAR (Treatment Administration Record). V2 said the standard nursing practice, if it was not signed or documented, then it was not done. He stated the purpose of moisture barrier cream is to prevent skin breakdown. V2 said he is aware of R1's wound culture. The result was received yesterday and showed CRE. He said R1 is currently on antibiotic for wound infection. V2 said if dressing was not changed or treatment was done as ordered, it could potentially lead to worsening/deterioration of the wound or infection.<br><br>On 6/23/25 at 10:44AM V26 (Wound Doctor) was interviewed via phone and stated he has been a Wound MD for 30 years and servicing the facility for over a year. He said he comes to the facility once a week to see/evaluate resident's wounds/pressure ulcers. V26 said wound treatment should be done and dressing should be changed as ordered. If the staff is not providing wound care or treatment or if the dressing not changed as ordered, it could lead to worsening of wound or infection. V26 said moisture barrier cream with zinc is to prevent skin breakdown. He said he is following R1 and aware of sacral wound culture result with current order of antibiotic for wound infection.<br><br>Skin/Wound Notes dated 5/27/2025 showed in part: R1's sacral wound now extends to right buttock.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1's May and June 2025 TAR (Treatment Administration Record) showed treatment order not limited to: Moisture Barrier with Zinc 10% Apply to buttocks topically every shift for Skin Care. Treatment order was not signed as treatment was provided on the following dates: 5/13/25 to 5/27/25, 5/30/25, 6/7/28 to 6/9/25, 6/12/25 and 6/16/25 to 6/21/25.<br><br>V24's (NP) notes dated 6/21/2025 documented in part: R1 was seen by a wound care team, concerned about infection. Culture was collected and started on doxycycline.<br><br>V26 (Wound Doctor) notes dated 5/15/25 showed in part: R1 with unstageable pressure on sacral measured 2.5 x 1.5 x 0.1cm. V26's notes dated 6/19/25 showed Unstageable pressure on sacral measured 9 x 7 x 0. 3cm. Recommended: Doxycycline for wound infection.<br><br>R1's wound assessment report dated 5/13/25 showed in part: Sacrum - Unstageable pressure. Size: 2 x 1.3 cm x unknown depth. Wound assessment dated [DATE] showed in part: Sacrum extending to right buttock. Size: 8 x 8 cm x unknown depth.<br><br>R1's laboratory final result dated 6/21/25 showed in part: culture, wound: 1. Proteus mirabilis. 2. Ac. Baumanii - CRE. Isolation precautions may be required.<br><br>R1's POS (Physician Order Sheet) dated 6/22/25 showed active order not limited to:<br><br>-Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate) Give 1 tablet via G-Tube every 12 hours for Wound infection for 10 Days. Date ordered: 6/21/25.<br><br>-Ciprofloxacin HCl Tablet 500 MG Give 1 tablet by mouth every 12 hours for Wound Infection for 7 Days. Date ordered 6/21/25.<br><br>-Gentamicin Sulfate External Ointment 0.1 % (Gentamicin Sulfate (Topical) Apply to sacrum to R buttocks topically every day shift for wound care cleanse with NS, apply zinc oxide on peri-wound, apply Gentamicin to wound bed, calcium alginate cover with a foam dressing AND apply to sacrum to R buttocks topically as needed for wound care. Date ordered 6/12/25.<br><br>-Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to sacrum to R buttocks topically every day shift for unstageable pressure injury Cleanse with normal saline. Pat dry with gauze. Skin Prep to periwound. Apply treatment and cover with foam dressing. AND apply to sacrum to R buttocks topically as needed for wound care. Date ordered: 6/12/25.<br><br>-Moisture Barrier with Zinc 10% Apply to buttocks topically every shift for Skin Care. Date ordered 5/12/25.<br><br>Care plan dated 5/14/25 showed in part: R1 has Pressure Injury to Sacrum, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity related to: Cerebral Vascular Accident, History of Pressure Ulcers, Hypertension, Immobility, Incontinence of Bowel, and Incontinence of Urine. Care plan interventions included but not limited to: Moisture barrier cream/ointment after each incontinent episode. Treatment as ordered by provider.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Facility's pressure injury and skin condition assessment policy dated 1/17/18 showed in part: Dressings which are applied to pressure ulcers, wounds shall include the date of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness and signs and symptoms of infection. Physician ordered treatments shall be initialed by the staff on the electronic treatment administration record after each administration. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview and record review, the facility failed to (a) implement transmission-based precautions, (b) ensure staff wear proper PPE (Personal Protective Equipment), (c) post precaution sign to alert staff for instructions prior to entering the room, and (d) provide PPE supplies accessible to staff for 1 (R1) of 3 residents reviewed for improper nursing care. These failures have the potential to cross contaminate 15 residents assigned to V7 (Certified Nursing Assistant/CNA).<br><br>The findings include:<br><br>R1's admission record showed admit date on 5/12/2025 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, Essential (primary) hypertension, Aphasia following cerebral infarction, Dysphagia following cerebral infarction, Acute respiratory failure with hypoxia, Pneumonitis due to inhalation of food and vomit, Encounter for attention to gastrostomy, Pressure ulcer of sacral region unstageable.<br><br>R1's MDS (Minimum Data Set) dated 5/20/2025 showed R1 was rarely or never understood. She needed total assistance or dependent with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair / bed and toilet transfer. Always incontinent of bowel and bladder. MDS showed unstageable pressure ulcer that was present upon admission.<br><br>On 6/22/25 at 10:25AM observed R1's room with no door signage for TBP (Transmission Based Precautions), no isolation set up or PPE supplies by room entrance. Observed R1 resting on bed on moderate high back, alert, nonverbal, making incoherent sounds. R1 with enteral feeding infusing (brand name enteral feeding) 1.5 at 55ml/hr.<br><br>R1's POS (Physician Order Sheet) dated 6/22/25 reviewed with no order for transmission-based precautions or contact isolation. Enhanced Barrier Precautions every shift for Wounds/G-tube start date 5/13/25 was listed on the POS sheet.<br><br>On 6/22/25 At 10:35AM observed V10 (Licensed Practical Nurse/LPN) entered R1's room and not wearing proper PPE. V10 wore gloves but no gown.<br><br>On 6/22/25 AT 10:53am observed V7 (CNA) entered R1's room without wearing proper PPE. V7 was wearing gloves and not wearing a gown. V7 changed R1's incontinence brief and stated dressing on buttocks area is clean and intact. Observed V7 turned and repositioned R1 in bed.<br><br>On 6/22/25 At 11:54AM V24 (Inhouse Nurse Practitioner/NP) stated she is following R1, aware of the sacral wound, culture was taken, and result came out yesterday. V24 read wound culture result as positive for Proteus Mirabilis, A. Baumanii, CRE (Carbapenem-resistant Enterobacteriaceae), isolation precautions maybe required. V24 said R1 is currently on antibiotic treatment for wound infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/22/25 At 2:35PM V9 (Infection Preventionist/IP/LPN) stated if resident tested positive, including wound culture, and if recommended in the result for isolation precautions then it should be implemented. V9 said anyone that has an organism that could contact on the surface including CRE should be placed on contact isolation precautions. She stated if the resident is sharing a room, then room transfer should occur as soon as the result is known, and transmission-based precautions will be implemented. V9 stated PPE supplies should be available by room entrance, signage by the door should be posted to communicate with the staff of the precautions and the proper PPE to use. V9 said she is aware of R1's wound culture result that came out yesterday as CRE. She said contact isolation precautions was required but she was not available yesterday. V9 said R1 has a roommate and room transfer should have been done yesterday but it did not occur. She said the nurse on the floor should have an isolation set up such as door signage and PPE supplies by room entrance to communicate with staff what to do and proper PPE to wear before entering the room. V9 said R1 should be on contact precautions, staff going inside R1's room should wear proper PPE such as gloves and gown, so organism does not transfer to staff clothing or skin to prevent spread of infection or cross contamination. She said if staff assigned to care for R1 and was not wearing proper PPE, could possibly lead to cross contamination with other residents that she is assigned to.<br><br>On 6/22/25 At 2:54PM V2 (Director of Nursing/DON) stated he is aware of R1's wound culture, and the result was received yesterday and showed CRE. He said R1 has a roommate and should have been transferred to a single room as soon as the result was known. V2 said contract isolation precautions should have been implemented such as door signage posted by the door to communicate with staff regarding proper PPE to use before entering R1's room. He said PPE supplies should be available by R1's room entrance, there should be no excuse for it. He said wearing of proper PPE is important to prevent cross contamination and spread of infection. V2 said R1 should have been on contact isolation precautions and staff entering her room should wear proper PPE such gown and gloves.<br><br>R1's laboratory result dated 6/21/25 showed in part: culture, wound: 1. Proteus mirabilis. 2. Ac. Baumanii - CRE. Isolation precautions may be required.<br><br>Facility's census dated 6/22/25 showed 15 residents assigned to V7 (CNA).<br><br>Facility's Infection Precaution Guidelines dated 5/15/23 showed in part: It is the policy of this facility to, when necessary, prevent the transmission of infection within the facility through the use of isolation precautions. The Transmission-Based Precautions will be employed for known or suspected infections for which the route of transmission/prevention is known. Use Contact precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items. Precaution signs will be utilized to alert staff and visitors to see the nurse for instructions prior to entering the room.<br><br>Facility's contact precautions signage showed in part: Providers and staff must put on gloves before room entry. Put on gown before room entry. |