STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145669	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELEVATE CARE WAUKEGAN	**2222 WEST 14TH STREET WAUKEGAN, IL 60085**

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an involuntarily discharged resident was allowed to return to the facility during the appeal process, and failed to ensure a resident was allowed to return to the facility after a hospital transfer for 2 of 2 residents (R7, R8) reviewed for involuntary discharge in the sample of 9. The findings include: 1.) R7's medical record shows she was initially admitted to the facility on [DATE]. Her face sheet shows that she is a [AGE] year old female that has [DIAGNOSES REDACTED]. R7's facility assessment dated [DATE] shows that her cognition is intact, she does not exhibit any behaviors of [MEDICAL CONDITION], disorganized thinking, physical or verbal aggression, threatening others, and does not refuse care provided to her. The same assessment shows that R7 is totally dependent on staff for bathing, toileting, eating, dressing, bed mobility, transfers, and personal hygiene. She is not able to walk, and cannot even turn side to side in bed without total staff assistance. R7's care plan provided by the facility, which list the focus and intervention sections as cancelled since she was discharged from the facility show the following: she requires the use of a voice activated motorized wheel chair with the use of a seat belt due to having poor trunk control, She has a suprapubic catheter, she is on a [MEDICATION NAME] pump, (medication to control muscle spasms for [MEDICAL CONDITION]) she requires a full body lift to be able to be transferred, she requires total staff dependence to complete her activities of daily living (ADL's), she has chronic pain, and she is a long- term resident. Her discharge potential is poor and she requires 24 hour care due to complex medical needs. R7's nursing progress notes show that on 7/6/2020 at 7:23 PM, an administrative note was written by V1 (Administrator) saying that R7 was asking a (Certified Nursing Assistant) CNA to sit in the room to feed her and she purposely ate in a slow manner so the CNA would have to sit in the room longer. On 7/7/2020 at 9:11 AM, a nursing progress not was written by V2, Director of Nursing (DON) showing that R7 was requesting her care to be done in a specific manner and if staff do not do as she likes she will call her husband who will then call Illinois Department of Public Health (IDPH) and they will come and investigate them. On 7/7/2020 at 4:41 PM, another administrative note was written in R7's chart by V1 stating that, Resident showed inappropriate behavior by demanding a CNA to clean the inner aspect of her vaginal area beyond the need of resident care. Resident was educated on the importance of appropriate behavior and when working with staff there are boundaries as well. on 7/7/2020 at 5:16 PM an entry by V2 was put in R7's progress notes stating, psych medical provider updated of resident's behavior. Received order to send to {a community hospital} for psych eval. On 7/7/2020 at 5:49 PM, V1 wrote another administrative note indicating she had informed resident's husband of inappropriate behaviors towards staff and how staff had made several complaints regarding feeling tortured due to threats or false accusations. In the same note V1 also says that she had notified R1's husband of the sexually inappropriate behaviors resident made towards a staff member demanding her to touch/ wipe her clitoris with no medical/health reason to do so. Also in the same note at the same time V1 stated Writer explained the involuntary discharge that is being issued due to resident creating an unsafe work environment, despite redirection and consultations resident has caused several staff members to state they are being harassed and threatened when caring for the resident . on 7/7/2020 at 7:23 PM, V1 made another entry into the progress notes showing that the resident was given an involuntary notice of discharge and the information on appealing it if she would like. The progress notes show that on 7/7/2020 at 8:30 PM, R7 was escorted out of the room on a stretcher and transferred to a hospital in Chicago. The same note says that the resident is aware but does not understand why she is being transferred she feels fine. R7's care plan provided by the facility does not show any prior episodes of sexually inappropriate behavior towards staff. R7's nursing home to hospital transfer form dated and signed on 7/7/2020 by V2 shows that the reason for transfer is agitation and [MEDICAL CONDITION] and the box indicating if nursing home would be able to accept resident back was not completed. A State of Illinois, IDPH, Notice of Involuntary Transfer and Discharge and Opportunity Hearing for Nursing Home Residents Form, was completed on 7/7/2020 by V1. The emergency transfer or discharge box is checked yes. The same document has the box checked indicating the reason for the involuntary discharge is due to the safety of individuals in the facility is endangered. There is a Department of Public Health legal form showing that there was a hearing to be held on 7/16/2020 and another one on 7/23/2020 relative to R7 filing an appeal to her involuntary discharge from the facility. R7's psychiatric evaluation from the community hospital she was sent to shows, that R7 was assessed as pleasant, and well spoken. The same evaluation shows that R7 stated that the nursing home had alleged she caused them fear even though she is a quadriplegic. Additional information from R7's hospital records show that R7 was actually taken off of her mood stabilizer, depression, and anxiety medications. On 7/28/2020 at 12:07 PM, V1 said that R7 was given a notice of discharge and sent to a psych facility due to some allegations of sexual inappropriateness to some staff. V1 said that R7's family had appealed the notice of involuntary discharge and there are hearings taking place. V1 said that R7 was recently discharged from the hospital and is currently residing at another long term care facility out of town. During the same interview when V1 was asked if she would have allowed R7 to return to the facility she stated I told the hospital I would help find them another place for her to go, I issued an Involuntary Discharge to her. On 7/28/2020 at 2:07 PM, V11 (Social Worker) said she was assigned to R7 while she was a resident there. V11 said that she was making rounds on the unit and she noticed that R7 was no longer there. V11 said that she asked where she went and was told she was involuntarily discharged and is not able to return. V11 said she had not noticed any recent changes with R7's behaviors at the facility. On 7/29/2020 at 9:30 AM, V13 (Physician) said that he was aware of R7 and had known her for a long time. V13 said his understanding of why she was discharged was because she had made some allegations against the staff and would not be coming back to the facility after the hospital stay. V13 also said that he had not seen R7 as psychotic, paranoid, delusional and the only time he saw any symptoms from her were if she had a urinary tract infection. V13 said he does not think that the psychiatrist saw any of those symptoms while she was at the hospital either. On 7/29/2020 at 10:10, V14 (Ombudsman) said that she had received the involuntary discharge paperwork for R7 and helped the family file an appeal for the involuntary discharge. V14 said she had just spoke with R7 on 7/28/2020 and R7 told her she would be willing to return to the facility. V14 said in her opinion she didn't see any evidence to warrant an involuntary discharge. She additionally said that R7 is at another long term care facility now and badly wants to be transferred closer to home. On 7/29/2020 at 10:01 AM, V15 (Social Worker from community hospital) said that she was familiar with R7 as she was transferred to the hospital she works at from the nursing home and was not able to return. V15 said she tried many long term care facilities before she finally found one for R7. V15 also said she did assist R7 and the family to file an appeal for the involuntary discharge. V15 said while R7 was in the hospital she saw her as pleasant, compliant, calm, and understanding. She also said that R7's power of attorney wanted her to return to the facility she was involuntarily discharged from. On 7/29/2020 at 8:40 AM, V18 (R7's spouse and Power of Attorney) stated that he feels she was given the involuntary discharge due to all the complaints that the family have called into the IDPH hotline. He said he

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145669	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELEVATE CARE WAUKEGAN	**2222 WEST 14TH STREET WAUKEGAN, IL 60085**

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) was just suddenly called one day by V1 telling him R7 was being transferred to a psychiatric hospital for aggression. V18 said he did want her to remain at that facility and he has an ongoing appeal. V18 said that R7 is a quadriplegic and cannot hurt anyone, and has never been sexually inappropriate or aggressive with anyone. V18 also said the new facility that R7 was placed at is over an hour and a half away from him. On 7/29/2020 at 12:02 PM, V19 (CNA) said that she is familiar with R7 and had taken care of her many times. She said she has never seen R7 as paranoid or delusional unless she had a UTI she would then say things that are not right. She said she didn't notice a change in her behaviors on the day she was discharged . V19 also said she was shocked when she came in to work one day and R7 was discharged . On 7/30/2020 at 1:09 PM, R7 was interviewed by phone, and said she was completely shocked when the facility and V1 gave her a notice of discharge. She said they came in and told me I was going to the hospital and I kept asking if I was coming back but they waited until right before I was going out the door and gave me involuntary discharge papers. She said I think they did it because of the complaints recently made against some CNA's at the facility. R7 went on to say V1 told her the staff were afraid of me but I am a quadriplegic and have never been in a psychiatric facility in my life. She also said initially she did want to return to the facility and her husband filed an appeal about the discharge. 2.) R8's face sheet shows that his admitted to the facility was 7/23/2013. He has [DIAGNOSES REDACTED]. R8's facility assessment dated [DATE], show that his cognition is in intact, he is able to dress, bathe, and do his personal hygiene independently. R8's care plan provided by the facility with the focus and interventions sections listed as cancelled (due to R8 being discharged) show that he is morbidly obese weighing over 500 lbs. He has an anxiety disorder, he is ventilator dependent, has a [MEDICAL CONDITION], he has not been getting up out of bed, he requires the use of an overhead trapeze to reposition in bed, has a private room, orders items off the internet, and has items hoarded in his room. R8's 6/24/2020 nursing progress notes show at 1:23 PM, V1 wrote an entry stating that R8 has refused all care and is at risk for SI due to refusal of medical care. {V13 (physician)} were contacted and both parties agreed he needs to be sent out immediately due to refusal of care and at major risk for medical decline. That same entry shows that R8 was refusing to allow his trachea tube to be changed. R8's Nursing Home to Hospital Transfer Form dated 6/24/2020 and completed by V2 shows that he was sent to a local community emergency room due to refusal to have [MEDICAL CONDITION]. The same document shows the box indicating if the nursing home would accept him back was left blank. R8's nursing progress notes written by V13 show he was involuntarily admitted to a local community hospital on [DATE]. A Social Service progress note dated 6/25/2020 at 4:09 PM, written by V17 shows that R8's room was deep cleaned by staff and there were numerous items found including chemicals (cleaning supplies), air fresheners, dust, unlabeled foods, and extension cords. Another entry was made into the social service notes at 4:24 PM by V11 showing that R8's belongings had been inventoried and his brother would be coming to pick up some of the items. On 6/25/2020 at 4:57 PM, V1 wrote a discharge summary note in R8's medical record stating that R8 was issued an involuntary discharge due to refusal to allow trachea care and for creating a suicidal living arrangement as evidenced by massive amounts of chemicals in his room, boxes hoarded, and dust build up. A notice of Involuntary Transfer or discharge and opportunity for hearing for nursing home resident form was completed by V1 on 6/25/2020 and issued to R8. On that form the reason for the discharge has the box checked that the safety of individuals in the facility is endangered. On 7/29/2020 at 9:10 AM, V1 said that she issued the involuntary discharge to R8 because of all the cleaning supplies and hoarding in his room and she saw as a safety concern and fire hazard. When asked why they didn't just remove the contraband items and send them home as planned with R8's family, she said that his family had been very upset and threatened the facility because she had involuntarily sent R8 out to the hospital. V1 also said that R8 did not want them to clean his room and stated we can't just go into his room. (The room had already been cleaned and R8 was in the hospital). On 7/29/2020 at 9:30 AM, V13 said that his understanding of why the facility issued the discharge to R8 was because R8's family had threatened the facility. V13 said R8 ended up remaining in the hospital for over 25 days and was just discharged on [DATE] from the hospital. V13 said the facility would not take him back even though he initially did want to return to the same facility. V13 said R8 was not able to manage at home and had to be placed in a skilled nursing facility in Chicago for ventilator dependent residents. On 7/29/2020 at 10:10 AM, V14 said that she did not see R8's discharge as emergent and is not sure why they didn't just send the items home that were not allowed in his room. On 7/29/2020 at 10:30 AM, V17 said that she had seen R8 in the past and her understanding of why he was involuntarily discharged was because of all the clutter in his room. V17 said with R8 staff had to pick and choose their battles because it was tricky dealing with R8. She also said that R8 had been at the facility for a long time and was very upset when he was sent out to the hospital. Attempts to contact R8 by phone were unsuccessful. The facilities Resident and Family Handbook dated 10/13 on page 5, under the section titled your rights to stay in the facility states, you must be allowed to return to the facility when you leave the hospital even if the facility has given you a Notice of Involuntary Transfer or Discharge. If you are hospitalized for [REDACTED].