STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145171	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Northbrook	270 Skokie Highway Northbrook, IL 60062

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement its policy for Abuse prevention program. This deficiency affects all four (R2, R3, R4 and R5) residents reviewed for Abuse prevention program. Findings include:On 10/8/25 at 1:30PM, V4 SSD (Social Service Director) said that as part of Abuse prevention program, Abuse/trauma assessment is completed upon resident admission, quarterly assessment, annually and as needed when there is allegation or incident of abuse. Abuse assessment score of above 2 indicates at risk for abuse and abuse prevention care plan should be initiated. Abuse prevention care plan is updated after investigation of allegation or incident of abuse or resident to resident altercation. On 10/9/25 at 9:30AM, V13 Care plan Coordinator said that Abuse prevention care plan is updated when there is an allegation or incident of abuse. V4 SSD is responsible for completing abuse assessment and updating abuse prevention care plan. 1.On 10/8/25 at 11:43AM, Observed R2 sitting on his bed. He is alert and responds coherently. He can verbalize his needs to staff. R2 is initially admitted on [DATE] with diagnosis listed in part but not limited to non-ST elevation myocardial infarction, Atherosclerosis, Ischemic cardiomyopathy, Anxiety disorder, Major depressive disorder. Abuse/Trauma assessment done on 9/27/22 with score of 0, not at risk for abuse but Abuse prevention care plan was initiated. On 8/29/25, physical resident to resident altercation investigation report was submitted to IDPH between R2 and R4. Abuse/trauma assessment was completed on 8/29/25 with score of 8 at risk for abuse but abuse prevention care plan was not updated. On 10/9/25 at 9:42AM, Reviewed R2's medical records with V4 SSD. Informed V4 of concern identified with R2 regarding implementation of abuse prevention program policy. Abuse prevention care plan was not updated after resident-to-resident physical altercation incident occurred on 8/29/25. V4 said that he should update the abuse prevention care plan after a resident-to-resident altercation report investigation. 2.On 10/8/25 at 11:23AM, Observed R3 sitting on his bed. He is alert and responds coherently. He can verbalize his needs to staff. R3 is initially admitted on [DATE] with diagnosis listed in part but not limited to Atherosclerotic heart disease, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, Presence of cardiac implants, Atrial fibrillation, Alcoholic liver cirrhosis, Bipolar disorder, Schizoaffective disorder, Abuse/Trauma assessment done on 6/25/24 indicated score of 4 at risk for Abuse/trauma related symptomatology. No Abuse prevention care plan was initiated. On 1/18/25, verbal and physical resident to resident altercation investigation report was submitted to IDPH between R3 and former resident in the facility. Abuse/Trauma assessment was done on 1/21/25 with score of 9 at risk for abuse but no abuse prevention care plan was initiated and updated. On 10/9/25 at 10:00AM, Reviewed R3 medical records with V4 SSD. Informed V4 of concern identified with R3 regarding implementation of abuse prevention program policy. No abuse prevention care plan was initiated when Abuse /Trauma assessment scored 4 and 9 indicated at risk for Abuse. No abuse prevention care plan was initiated and updated after resident-to-resident physical altercation incident occurred on 1/18/25. V4 said that he should initiate an abuse prevention care plan when abuse trauma assessment triggered score of 2 or more and he should update the abuse prevention care plan after an allegation report investigation of resident-to-resident altercation. 3.On 10/8/25 at 11:58AM, Observed R4 sitting at the hallway. He is alert but confused with flight of ideas. He responds incoherently. R4 is initially admitted on [DATE] with diagnosis listed in part but limited to Parkinson's disease, schizoaffective disorder bipolar type, Alcohol abuse intoxication, Age related cataract bilateral. Abuse/Trauma assessment done on 1/24/24 indicated score of 6 at risk for abuse/trauma related symptomatology. No Abuse prevention care plan was initiated. On 8/29/25, physical resident to resident altercation investigation report was submitted to IDPH between R4 and R2. Abuse/trauma assessment was completed on 8/29/25 with score of 9 at risk for abuse but no abuse prevention care plan was initiated and updated. On 10/9/25 at 10:12AM, Reviewed R4 medical records with V4 SSD. Informed V4 of concern identified with R4 regarding implementation of abuse prevention program policy. No abuse prevention care plan was initiated when Abuse /Trauma assessment scored 6 and 9 indicated at risk for Abuse. No abuse prevention care plan was initiated and updated after resident-to-resident physical altercation incident occurred on 8/25/25. V4 said that he should initiate an abuse prevention care plan when abuse trauma assessment triggered score of 2 or more and he should update the abuse prevention care plan after an allegation report investigation of resident-to-resident altercation. 4.On 10/9/25 at 11:30AM, Observed R5 lying in bed. She is alert and responds coherently. She