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	06/23/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comply with its Abuse and Retaliation Policy and Prevention Program by failing to protect a resident from staff abuse. This failure resulted in severe pain for 1 of 3 residents (R1) reviewed for abuse in a sample of 5.The findings include:R1 is a [AGE] year-old female admitted on [DATE], having moderate cognitive impairment as per the minimum data set (MDS) dated [DATE].On 6/16/26 at 9:45 AM, R1's door was closed, and a screaming sound was heard from R1's room. This surveyor knocked on the door and found that V7 (Certified Nursing Assistant /CNA) was providing care for R1. The surveyor stepped back and closed R1's door and remained in the hallway talking to another resident (R6) adjacent to R1's room.On 6/16/26 at 9:48 AM, the surveyor heard louder screaming from R1 and observed that R1 had turned to her left side with a right knee immobilizer and multiple pieces of linen on the floor. V7 responded that she is doing patient care. The surveyor stepped back, leaving the door closed. V3 (social service director) encountered this surveyor while exiting R1's room, handed over the requested documentation, and then heard another scream from R1. The surveyor requested that V3 check what was happening, as this surveyor had opened the door twice, and V7 wasn't happy to keep opening the door after each scream from R1.On 6/16/26 at 9:55 AM, V3 stated, V7 was providing care, and R1 was screaming because of the pain. V7 should have stopped care and reported the pain to the nurse.On 6/16/26 at 10:15 AM, R1 was observed in her bed along with R1's nurse (V4). R1 stated, I had a fall last week with a right knee fracture, and the CNA (V7) was very rough and hurtful. Observed V4 assessing R1 for pain, and R1 reported a pain level of 10 out of 10 with her right knee. V4 stated that R1 just woke up before patient care and wasn't this painful.On 6/16/26 at 11:50 AM, V2 (Director of Nursing) stated, When a resident screams and complains of pain during care, the staff should have stopped care and reported to the nurse. All the residents have the right to be free from abuse.On 6/17/26 at 1:00 PM, V1 (Administrator/Abuse Coordinator) stated, We suspended V7 and initiated an investigation. We sent the initial report to public health yesterday. All residents have the right to be free from abuse. V7 should not have proceeded with resident care when the resident was in pain.The facility presented Abuse and Retaliation Policy Prevention Program document: The facility is committed to protecting our residents from abuse, neglect, exploitation, retaliation, misappropriation of property, and mistreatment by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its Activities of Daily Living (ADL) care policy by failing to provide nail care to dependent residents. This applies to 1 of 3 residents reviewed (R3) for ADL care in a sample of 9.The findings include:R3 is a [AGE] year-old male admitted with mild cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. The MDS also documented that R3 requires supervision or touching assistance for personal hygiene.On 6/16/26 at 10:32 AM, R3 was observed with long, dirty nails with brownish colored dirt accumulated underneath the nails. The left thumbnail was observed to be around 7 millimeters long, with dirt under the nails.On 6/16/26 at 10:40 AM, V4 (R3's Nurse) stated, The Certified Nursing Assistants (CNAs) are supposed to provide nail care.A review of the nurse practitioner's note dated 6/5/26 documented that R3's sores started with insect bites, with some appearing excoriated with central crusting/scabbing, one appears to have scabbed from repeated scratching/picking, and upon today's examination, the lesions are less red and inflamed.On 6/16/26 at 11:45 AM, V2 (Director of Nursing) stated, The CNAs are supposed to provide nail care. Having long, dirty nails can cause skin damage.The facility presented the ADL Care policy, reviewed on 6/15/26, document:Grooming: Maintaining personal hygiene, including planning the risk and gathering supplies, combing and/or styling hair, washing face and hands, shaving, applying makeup, nail care, and/or application of deodorant or powder.

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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 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** Based on observation, interview, and record review, the facility failed to follow its Fall Prevention Program by failing to implement appropriate interventions to ensure the safety of fall-risk residents for 1 of 3 residents (R1) reviewed for falls. This failure has resulted in a fall with a right distal femur fracture. The facility also failed to follow its elopement policy by failing to monitor and prevent the departure of an elopement-risk resident for 1 of 3 residents (R7) reviewed for elopement. Findings include:1. R1 is a [AGE] year-old female admitted on [DATE], having moderate cognitive impairment as per the minimum data set (MDS) dated [DATE].On 6/16/26 at 10:15 AM, R1 was observed in her bed along with R1's nurse (V4). R1 stated, I had a fall last week, and I can't recall how I fell.On 6/16/26 at 10:15 AM, R1's call light was observed hanging from the wall behind the headboard and the bedside table with a water cup and remote on her right side (behind head), and was not within reach.On 6/16/26 at 10:15 AM, V4 stated that the call light should have been accessible to R1, and the bedside table with water and TV remote should be within her reach.On 61/7/26 at 12:45 PM, R1 was observed in her bed with a call light string under her pillow and buried under the linen. The resident was unable to locate the call light upon request.On 6/17/26 at 12:50 PM, V4 asked R1 to use the call light, but R1 replied that she didn't know where it was. Observed V4 got it for R1 and stated, The call light should be within her reach.On 6/17/26 at 11:00 AM, V6 (R1's nurse on duty on 6/5/26) stated, R1 had a fall at around 9:30 PM on 6/5/26. No one witnessed her fall. R1 is bed-bound but can roll left and right. She was trying to reach for something, and the CNA (V5) found her on the floor, with the remote also on the floor.On 6/16/26 at 10:05 AM, V8 (Nurse) stated, R1 is bed-bound, and always calls for help. On 6/5/26, R1 was trying to reach out for something from the table and fell with a right femur fracture.A review of the fall risk assessment dated [DATE] documented that R1 was at high risk for falls.A review of the care plan documented fall care plan interventions including: call light placed within easy reach at all times, personal items within reach such as water, TV remote control, pen, paper etc.A review of the reportable documented a fall with right distal femur fracture was reported to public health on 6/5/26.The hospital's Computerized Tomography (CT) of the right thigh/femur dated 6/6/26 resulted in an acute comminuted intra-articular fracture of the distal right femur.The facility provided hospital record Discharge summary dated [DATE] documented that R1 was admitted there for right distal femur fracture from a fall and underwent Open Reduction Internal Fixation (ORIF) of right distal femur fracture.On 6/16/26 at 11:45 AM, V2 (Director of Nursing) stated, R1 had a fall on 6/5/26 with a fracture of her right distal femur. No one witnessed the fall. I must relay what the staff told me to determine the root cause. I heard from staff that R1 was trying to reach out for something, and she fell. R1 should have her bedside table and her call light always within her reach.A review of the Fall Prevention Program provided revised on 11/21/17 purpose statement document: To assure the safety of all residents in the facility, when possible. The program will include measures that determine the individual needs of each resident by assessing fall risk and implementing appropriate interventions, including the use of necessary supervision and assistive devices. Fall Safety interventions may include, but are not limited to: the residents' personal possessions will be maintained within reach when possible. These items include tissues, water, drinking glass, and phone.2. R7 is a [AGE] year-old female admitted on [DATE] with cognition intact as per the Minimum Data Set (MDS) dated [DATE].On 6/19/26 at 9:35 AM, R7 stated, On Sunday, 6/14/26, I used the elevator from the second floor to the ground floor, and I was able to walk through the front door at 5:00 pm. I just walked out, and no one stopped me. I was trying to go home. There is no reason why I am here.On 6/19/26 at 11:00 AM, V15 (Police Officer) stated, We received a call from a motorist who observed R7 wandering around the car dealership. I met her at the dealer's shop. She was stumbling and swinging back and forth. I checked our system and found that R7 had an elopement from this (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility (under previous management) in 2016. So, I brought her to the facility, and R7 confirmed that she belongs there. The facility was not even aware that R7 was missing until I brought her there.On 6/19/26 at 2:15 PM, V13 (R7's nurse on 6/14/26 PM Shift) stated, The CNA, during the round to remove the dinner tray at around 5:30 pm, noticed that R7's dinner tray was not touched. She called me, and we both looked for R7 throughout the unit. I called V12 (Nurse supervisor), and V12 called, code green. The police were already here with R7 around 6:00 pm, before we called them to report the elopement.On 6/20/26 at 10:30 AM, V17 (R7's assigned CNA on 6/14/26 PM shift) stated, I did head count at the start of my shift on 6/14/26, and R7 was on her bed. We passed dinner early that day, around 4:30 PM. R7 didn't eat her dinner, and after I removed her tray around 5:00 PM, I couldn't find her. I thought she might have gone to the nurses' station to grab something. I didn't know she was at risk of elopement. She was always in bed. Sometimes, she comes to the nurses' station to get something and will go back to her bed.On 6/19/26 at 2:45 pm, V14 (Receptionist on 6/14/26 PM shift) stated, I am new and have been here only six months. On Sundays, we have so many families visiting our residents. In that heavy traffic, I didn't notice R6 sneak out through the visitors. Sorry, it was my mistake.On 6/19/26 at 9:40 am, V2 (DON) stated that it's not only the receptionist's responsibility but also everyone's to monitor elopement risk, residents.A review of the facility provided elopement policy guidelines document: All personnel are responsible for reporting a cognitively impaired resident attempting to leave the premises, or suspected of missing, to the charge nurse as soon as possible.