STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

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** 44103 Based on interview and record review, the facility failing to affirm the right of the resident (R2) to be free from physical abuse and to have a safe environment, resulting in R1 punching R2 in the face. This failure resulted in R2 crying, and R2 being afraid R1 would attack R2 again. Findings Include: R1's face sheet shows R1 has diagnoses including Schizophrenia and Unspecified Intellectual Disabilities. R1's Minimum Data Set (MDS), dated [DATE] and 12/22/24, shows R1 is cognitively intact with BIMS (Brief Interview for Mental Status) score of 15, and has the ability to walk. R1's behavior care plan documented: (dated initiated 3/21/2019) R1 displays behavioral symptoms related to severe mental illness. These are manifested by rummaging, or taking food off of food carts, or unattended food. R1 may become agitated when redirected and display aggressive behavior. R1 demonstrates behavioral distress as manifested by yelling to towards staff, residents physically abusive behavior when agitated; attempting to push, shove, scratch, or otherwise harm another person. This behavior occurs 1-3 times per week and is related to being challenged by mental illness, ineffective coping mechanisms. R2's face sheet shows R2 has diagnoses including Hemiplegia Affecting Right Dominant Side, Vascular Dementia, Schizoaffective Disorder, Anxiety Disorder, Right Hand Contracture, and Epilepsy. R2's MDS, dated [DATE], shows R2 has moderately impaired cognition with BIMS of 12 and requires substantial maximal assistance from staff with activities of daily living. (continued on next page)

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	R2's progress notes, dated 12/8/24 at 1:28 PM, documented by V11 (Agency Nurse) reads: (R2) was involved with another patient's behavior issue. (R1) was eating lunch wanted more food so (R1) walked to the cart in the hall. (R1) did not see a tray that he could take off the cart so (R1) started pulling used trays off the cart in anger. (R1) walked to the nurses' station and started throwing things. (R2) was sitting at the nurses' station eating and being observed due to fall risk when it was reported that (R1) struck (R2). Both patients were immediately separated and (R1) was placed on one-one observation. NP (Nurse Practitioner) and Family were made aware and (R2) was given a shot of Ativan to calm (R2) down and reported seizures noted following incident. (V10, Assistant Director of Nursing) and all other necessary parties made aware. The facility's final abuse reportable sent to the State Agency (SA) documented: Incident date was 12/8/24 at 1:05 PM. Based on a complete and thorough investigation, (R1) had just finished with his lunch and brought his lunch tray back to the food cart for collection, as per his routine and baseline. (R1) was still hungry and instead of asking the staff for more food from the kitchen, he stated he thought he would look for an extra tray on the cart that he could take food from. (V8, Former Certified Nursing Assistant/CNA) saw (R1) attempting to take someone else's tray of food and asked (R1) if he was still hungry, he could get him another tray or plate of food. Politely, (V8) also asked (R1) to please not take any food off the trays on the cart as they belong to other residents. Suddenly, (R1) became upset and walked away. (R2) was near the area of the event and as (R1) walked away, (R1) abruptly made unwanted contact with (R2) using an open hand. (V8) witnessed the incident and immediately separated (R1) from (R2). (R1) apologized at that moment and was assisted back to his room, kept under direct supervision, and was also provided with a new tray of food as per (R1's) request. V8's witness statement from the facility's investigation, dated 12/8/24, documented, (R1) was going through the lunch trays. I told (R1) to stop. (R1) got upset and began throwing trays off the cart and throwing a box at me. (R1) went to (R2) who was sitting eating (R2's) lunch and hit (R2). (V17, Certified Nursing Assistant) tried to stop (R1) and once we attmepted to redirect and get the nurse (R1) apologized. On 1/26/25 at 9:54 AM, R2 stated R2 does not remember another resident punching R2 on the face. R2 stated, I don't remember that incident. I usually remember something like that, but I don't remember. R2 stated R2 knows R2 is forgetful. R2 stated R2 had stroke and has had many seizure episodes. R2 stated R2 does not walk anymore and R2's right side is paralyzed. On 1/26/25 at 10:01 AM, R1 stated, I'm upset. I always get upset. When I'm angry, I hit people. When surveyor asked R1 to clarify what R1 had just said, R1 repeated the same answer, I'm upset. I always get upset. When I'm angry, I hit people. R1 stated R1 is not angry or upset now, but R1 refused to answer further interview questions. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/26/25 at 11:09 AM, a phone interview was conducted with V8 (Former CNA). V8 stated, It happened around lunch time the incident was about the lunch tray. (R1) wanted to dig in and I told him to stop twice; the third time (R1) got upset. (R1) ran over to me. (R1) threw everything at me whatever he could grab from the nurses' station. I did not give (R1) any reaction. I just stood there and looked at (R1). I was just looking at (R1). (R1) didn't stop and when (R1) saw that I was not reacting to his behavior, (R1) went straight to (R2) and punched (R2) in the face. (R2) cried. (R2's) face was really red from the punch. (R2) was sitting on a geri (geriatric) chair by the nurses' station because we would always put (R2) there to closely monitor him because (R2) has history of seizures. (R2) was crying and (R2) said that he was scared that (R1) would come back and attack (R2) again. (R2's) face was red. When this happened, I immediately go get the nurse. They were agency nurses; they told me to call the ADON (V10, Assistant Director of Nursing). I went back to the nurses' station and saw (R1) was trying to throw food at (V17, CNA). I called the ADON and was told to call the police. I called the police and then the ADON came up and talked to (R1). Right after this incident, a few minutes later after (R2) got punched, (R2) had seizures. I don't know who checked on (R2). On 1/26/25 at 3:21 PM, V8 verified R1 came up to R2 and intentionally punched R2 in the face because R1 had seen V8 did not react to R1's aggressive behavior. V8 stated after R1 punched R2, R1 apologized. V8 stated R1 punching R2 is a type of physical abuse because R1 hit R2 knowing R2 could not move and could not defend himself. On 1/26/25 at 11:23 AM, V17 (Certified Nursing Assistant) V17 stated V17 did not witness the initial incident. V17 stated, I was passing by and I heard (V8) telling (R1) to stop. I saw (R1) angry and (R1) was trying to throw food at me. I backed away. I went to go ask for help. I called (V8) back and told (V8). On 1/26/25 at 12:27 PM, V10 (Assistant Director of Nursing) stated V10 was doing rounds in the building, and was stopping on the fourth floor, and the staff was saying to V10 that R1 had just hit R2 in the face. V10 stated V10 instructed the staff to immediately separate R1 and R2. R1 was placed on one-on-one supervision and R2 was assessed. V10 stated V10 assessed R2 with the nurse, but does not remember which nurse. V10 stated R2's face was slightly red, but no open wounds. V10 stated originally, R2 said he was okay, but then R2 said R2 was anxious and nervous about R1 hitting R2. V10 stated R2 did not say R2 was scared. V10 stated approximately 6 minutes after the incident, R2 had two seizures that lasted for 4 to 5 minutes. On 1/26/25 at 10:08 AM, V7 (Certified Nursing Assistant) stated R1 has impulsive behavior. V7 stated R1 would throw stuff when R1's mad. V7 stated R1 is not always mad, but when R1 gets upset, R1 would try to hit people, like staff or other residents. R1 needs to be re-directed when he's upset because when R1's upset he would be throwing things and try to hit other people. V7 stated it's R1's behavior ever since and R1 has a history of getting physically aggressive with staff and residents when R1's upset. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/26/25 at 11:01 AM, V16 (Social Service Director). stated R1 is alert and oriented times 3-4 (person, place, time, event) and is pretty aware. V16 stated R1 has little bit of anger/temperament issues at times when R1 is confused and overstimulated. V16 stated R1 gets agitated at times and requires re-direction if R1's unfamiliar with staff; sometimes R1 has been known to grab trays. V16 stated R1 had history of being agitated and if that happens, staff needs to provide brief one on one with R1. V16 stated when R1 is agitated, Staff needs to remove (R1) from the situation and provide one to one counselling to calm (R1) down. Talk to (R1). (R1) is usually able to tell you. (R1) will most likely apologize. (R1) has impulsive behaviors and has problem solving impairment. If (R1's) upset or agitated, right away, staff needs to calm (R1) down and talk to (R1) and re-direct (R1). For example, tell (R1) to come walk with me or talk to me. If you don't address the behavior or try to talk back with (R1), it will become worse. It will continue to escalate (R1's) anger. On 1/26/25 at 11:53 AM, V2 (Director of Nursing) stated abuse is anything that puts the resident in an intentional harm. The types of abuse are physical, verbal, sexual, financial, emotional. V2 stated an example of physical abuse is hitting a resident. On 1/26/25 at 2:29 PM, V1 (Administrator) stated the residents have all the right to be safe in the facility, to be able to be free from abuse and feel at home, and state anything without any repercussion, and be part of their care. V1 stated if there is a resident-to-resident altercation, the residents should be separated immediately. V1 stated the incident that happened between R1 and R2 on 12/8/24 was not a form of physical abuse, because R1 acted unintentionally. V1 stated the reason why R1 and R2 were not sent out to the hospital for further evaluation was because V1 feels like it was not a form of abuse based on V1's investigation. On 1/27/25 at 11:35 AM, V11 (Agency Nurse) stated, I just remember that I was called by the CNA I don't remember who was the CNA. I was told that (R1) struck (R2) on the face. I did not witness it. The facility's Abuse Prevention and Reporting policy, dated 10/24/22, documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation or property, and mistreatment of residents. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The facility's RESIDENTS' RIGHTS policy (undated) documents: The residents have the right to safety, must not be abused and residents' facility must be safe, clean, comfortable and homelike.

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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** 47304 Based on observation, interview, and record review, the facility failed to provide proper and adequate care (oral hygiene, grooming and shower / hair wash) and develop an individualized plan of care for 1 (R3) resident who is dependent with care. These failures affected one (R3) of three residents reviewed for improper nursing care. Findings include: R3's MDS (Minimum Data Set), dated 1/7/2025, showed R3's cognition was severely impaired. R3 needed total assistance / dependent with oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing. R3' order summary report, dated 1/26/25, with active order, Oral Care every 8 hours and as needed. R3's care plan date, initiated on 5/22/20, documented: R3 has a tracheostomy and ventilator due to chronic respiratory failure. Care plan interventions included but not limited to Provide good oral care every shift and PRN (as needed). R3's care plan, dated 6/9/2020, documented: Is Ventilator dependent related to Respiratory Failure. Care plan interventions included but not limited to Provide good oral care every shift. R3's care plan date, initiated on 5/22/20, documented: R3 has an ADL Self Care Performance Deficit related to deconditioning with Limited Mobility, Pain. Care plan did not show the types and amount of ADL care R3 needed as reflected in the comprehensive assessment to meet R3's needs. R3's admission record showed initial admitted [DATE], with diagnoses not limited to Chronic respiratory failure, Encounter for attention to tracheostomy, Dependence on respirator [ventilator] status, Encounter for attention to gastrostomy, Heart failure, Epilepsy, Anoxic brain damage, Hypoxic ischemic encephalopathy, Pressure ulcer of sacral region stage 4, Hypertensive heart disease with heart failure, Neuromuscular dysfunction of bladder, Contracture of muscle multiple sites, Pneumonia. R3's record showed hospitalization on [DATE], and readmitted [DATE]. On 1/26/25 At 9:38 AM, R3 was observed lying in bed, on moderate high back rest, non-verbal, with enteral feeding hanging on the pole at bedside, with tracheostomy attached to ventilator machine, with indwelling urinary catheter. R3 appeared unkempt, hair oily / greasy, matted / tangled, with scaly and flaky scalp, teeth discolored / yellowish, with buildup of mucus / saliva or whitish matter around mouth and teeth, lips with buildup of dry brownish debris. R3's fingernail uneven and overgrown, skin dry and flaky. On 1/26/25 At 10:04 AM, V10 (Assistant Director of Nursing/ADON) stated R3's hair is oily / greasy with white patches. She said bed bath / hair wash is scheduled at least twice a week and as needed, and she was not sure when was the last time R3's hair was washed / shampooed. She said it does not look R3's hair was washed / shampooed as scheduled twice a week, because of how it appears. V10 said staff is expected to provide oral care every shift. She said it does not look like mouth care is being done every shift due to buildup in R3's mouth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/25 At 10:32 AM, V15 (Certified Nursing Assistant / CNA), assigned CNA for R3's room, stated she had checked R3 before breakfast and has not done oral care yet. She said oral care is done every shift and bed bath / shower / hair wash is scheduled twice weekly and as needed. V15 stated she did not know when the last hair wash or oral care was done to R3. She said R3 is bed bound and needed total care. V15 took equipment and brought to bedside. V15 placed towel under R3's head and started hair wash, using rinse free shampoo cap. Shampoo cap turned to discolored yellowish to brownish and another shampoo cap was needed to cleanse hair / scalp. V15 took another rinse free shampoo cap and cleanse R3's head and scalp. V15 brushed R3's matted and tangled hair. On 1/26/25 At 10:41 AM, V14 (RT / Respiratory Therapist) and V15 (CNA) came in R3's room. V14 performed tracheal suctioning to R3. V15 provided oral care to R3, and removed sticky whitish and brownish build up matter inside R3's mouth. Oral suctioning was done by V14. On 1/26/25 At 11:46 AM, V2 (Director of Nursing/ DON) stated she has been working in the facility for 2 years. V2 stated staff are expected to perform grooming / nail care / shaving to resident at least once a week every Sunday and as needed. V2 stated shower/ hair wash or bed bath is scheduled twice a week and as needed. She said staff are expected to use a rinse free shower cap for residents who are totally dependent / bed bound. V2 said facility has a higher incident of colonization of multi drug resistant organism, so staff are expected to make sure proper shower / hair wash / bed bath is given to prevent further incident and to maintain proper hygiene. She stated if showers are given as scheduled, the hair should not be matted, tangled, greasy, or oily. V2 said staff are expected to provide oral care every shift and as needed, to prevent bacteria that could sit in their mouth that can cause pneumonia, and for resident's hygiene. She said if proper oral hygiene is provided to the resident, there should be no build up in their mouth. V2 said R3 should not have oily / greasy, flaky / scaly scalp, matted / tangled hair, or build in R3's mouth if shower, and oral care should be done properly and as scheduled. She said oral hygiene, hair wash, nail care, and grooming are basic needs care that resident should receive. On 1/26/25 At 12:06 PM, V13 (Restorative Director, Licensed Practical Nurse/LPN) stated has been working in the facility for almost 5 years. He said R3 requires total assistance with ADL (activities of daily living) care and should be care planned. V13 said he is responsible for ADL care plan. V13 stated residents care plan should be individualized for ADL care so staff would be able to know how to care for the residents. He said care plan is a guide for the staff on how to care for residents. V13 said ADL care includes oral, personal, toileting, hygiene, upper and lower body dressing, shower / bathe self, grooming. V13, stated R3's ADL care plan did not reflect it was individualized for R3; it was a general care plan. He said it did not show how much care R3 needed or required for oral hygiene, shower / bathe self or grooming / nail care. Facility's oral hygiene policy dated 1/1/2014 documented in part: To provide oral care for the teeth, gums, and mouth. To promote resident comfort. Facility's bathing - complete bed bath policy, dated 1/31/18, documented: to ensure resident's cleanliness to maintain proper hygiene and dignity. A shower, tub bath or bed / sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or as requested. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's nail care policy, dated 1/25/18, documented: Observed condition of resident nails during time of bathing. Note cleanliness, length, uneven edges, hypertrophied nails. Trim fingernails in an oval fashion avoiding tissue after bathing or when needed. Apply lotion to nail area. Observe and report signs of dryness. Facility's comprehensive care plan policy, dated 11/17/17, documented: To develop a comprehensive care plan that directs the care team. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interview and record review, the facility failed to follow a resident's care plan, failed to follow their seizures policy to assess and document findings and observations of a resident's seizure activity, and failed to send a resident to the hospital for further evaluation who got punched in the face and is on anti-coagulant therapy with active seizures. These failures affected one (R2) out of three residents reviewed for abuse. Findings Include: R2's face sheet shows R2 diagnoses including Hemiplegia Affecting Right Dominant Side, Vascular Dementia, Schizoaffective Disorder, Anxiety Disorder, Right Hand Contracture, and Epilepsy. R2's Minimum Data Set/MDS, dated [DATE], shows R2 has moderately impaired cognition with BIMS (Brief Interview for Mental Status) of 12, and requires substantial maximal assistance from staff with activities of daily living. R2's December Medication Administration Record shows R2 is receiving anticoagulant therapy; Heparin injection every 12 hours. R2's comprehensive care plan documented R2 has Seizure Disorder (date initiated [DATE]). Interventions include Post Seizure Treatment: After seizure take vital signs and neuro check, monitor for aphasia, headache, altered level of consciousness, paralysis, weakness, pupillary changes. Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. R2's progress notes, dated [DATE] at 1:28 PM documented by V11 (Agency Nurse), reads: (R2) was involved with another patient's behavior issue. (R1) was eating lunch wanted more food so (R1) walked to the cart in the hall. (R1) did not see a tray that he could take off the cart so (R1) started pulling used trays off the cart in anger. (R1) walked to the nurses' station and started throwing things. (R2) was sitting at the nurses' station eating and being observed due to fall risk when it was reported that (R1) struck (R2). Both patients were immediately separated and (R1) was placed on one-one observation. NP (Nurse Practitioner) and Family were made aware and (R2) was given a shot of Ativan to calm (R2) down and reported seizures noted following incident. (V10, Assistant Director of Nursing) and all other necessary parties made aware. R2's clinical records do not show any documentation of R2's assessment findings and observations of R2 during and after R2's seizure activity. No documentation of vital signs, the type of seizure, R2's level of consciousness, the duration of the seizure, if neuro checks were done, and if R2 was monitored for any other acute changes in condition. R2's clinical records also do not show documentation if R2 was sent to the hospital for further evaluation post seizure activity after being punched by R1. On [DATE] at 9:54 AM, R2 stated R2 does not remember another resident punching R2 in the face. R2 stated, I don't remember that incident. I usually remember something like that, but I don't remember. R2 stated R2 knows R2 is forgetful. R2 stated R2 had a stroke and has had many seizure episodes. R2 stated R2 does not walk anymore and R2's right side is paralyzed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:09 AM, V8 (Former Certified Nursing Assistant/CNA) stated, It happened around lunch time; the incident was about the lunch tray. (R1) wanted to dig in and I told him to stop twice, the third time (R1) got upset (R1) ran over to me. (R1) threw everything at me; whatever he could grab from the nurses' station. I did not give (R1) any reaction. I just stood there and looked at (R1). I was just looking at (R1). (R1) didn't stop and when (R1) saw that I was not reacting to his behavior, (R1) went straight to (R2) and punched (R2) in the face. (R2) cried. (R2's) face was really red from the punch. (R2) was sitting on a geri (geriatric) chair by the nurses' stations because we would always put (R2) there to closely monitor him because (R2) has history of seizures. (R2) was crying and (R2) said that he was scared that (R1) would come back and attack (R2) again. (R2's) face was red. When this happened, I immediately went to get the nurse. They were agency nurses; they told me to call the ADON (V10, Assistant Director of Nursing). I went back to the nurses' station and saw (R1) was trying to throw food at (V17, CNA). I called the ADON and was told to call the police. I called the police and then the ADON came up and talked to (R1). Right after this incident, a few minutes later after (R2) got punched, (R2) had seizures. I don't know who checked on (R2). On [DATE] at 12:27 PM, V10 (Assistant Director of Nursing/ADON) stated V10 was doing rounds in the building, and was stopping on the fourth floor, and the staff was saying to V10 that R1 had just hit R2 in the face. V10 stated V10 instructed the staff to immediately separate R1 and R2. R1 was placed on one-on-one supervision and R2 was assessed. V10 stated V10 assessed R2 with the nurse, but does not remember which nurse. V10 stated R2's face was slightly red, but no open wounds. V10 stated originally, R2 said he was okay, but then R2 said R2 was anxious and nervous about R1 hitting R2. V10 stated R2 did not say R2 was scared. V10 stated approximately 6 minutes after the incident, R2 had two seizures that lasted for 4 to 5 minutes. V10 stated, The whole time (R2) was shaking but still able to make conversation. (R2) was alert. (R2) had seizures at least twice. Both times (R2) was alert. The nurse assessed (R2) after the seizures. The Nurse Practitioner (NP) was in the building. I don't know what time (V9, In-House NP) saw (R2). I told the agency nurse that (V9) was in the building. I also called (V9). I did not document; I hope the nurse did. The standard nursing practice is that the nurse should be documenting the services and the interventions provided. If it's not documented there is no documentation to support that the interventions and services were rendered. I don't remember if (R2) was sent out to the hospital after the seizures. On [DATE] at 11:53 AM, V2 (Director of Nursing) stated V2 was notified that R1 inadvertently hit R2 in the face. V2 stated R2 had a seizure after the incident. V2 stated V2's expectation is that after a resident's seizure activity, the nurse should check the resident's vital signs, keep the resident safe, and call emergency (911). V2 stated even if the seizure stops and seems the resident is stable, every time they have a seizure they have to call 911. V2 stated V2 does not remember if R2 was sent to the hospital after the seizure. V2 stated, If we don't send the resident to the hospital after the seizure then we won't know if they potentially have other complications from the seizure. We won't know how bad the seizure was. On [DATE] at 2:46 PM, V10 (ADON) stated V10's mind was not clear during the first interview, and V10 provided the wrong information. V10 stated V10 notified V18 (Nurse Practitioner) of R2's seizure activity on [DATE], and not V9. However, V10 stated V10 did not also document this notification and did not document what was ordered by V18. V10 stated V10 texted V18. R2's progress notes also do not show any documentation from V18 that V18 was notified of the incident and R2's seizure activity on [DATE]. (continued on next page)

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	145484	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:00 PM, V2 and asked to clarify what is documented on the facility's Seizure policy. V2 stated, It means that if a resident experiences a seizure activity, the nurse should assess and document the resident's vital signs, any changes, any vomiting, the type of seizure, the resident's cognition, if they lose consciousness, respiratory condition, and if the resident is in distress. V2 stated the complete assessment and observation should be documented in the resident's electronic chart. On [DATE] at 3:06 PM, V9 (In-House Nurse Practitioner/NP) and stated V9 was not notified of R2 being punched by R1 in the face. V9 also stated V9 was not notified of R2's seizure activity after the incident. V9 stated V9 was in the facility on [DATE] because V9 is the weekend in-house NP. V9 stated if V9 was notified of R2's seizure activity and being punched in the face, V9 would order for R2 to be sent out to the hospital for further evaluation because R2 is on anticoagulant therapy. V9 stated, It is the same protocol if a resident falls and is on anticoagulants. We need to send the resident out to the hospital for their safety. They need to be checked and conduct further testing to see if the resident sustains other complications. V9 also stated after seizure activity, the nurse should be documenting how long was the seizure lasted, what type of seizure, and what was the condition of the resident. V9 stated V9's documentation on R2's progress notes on [DATE] was to follow up about the fall, and not about the seizure activity or the incident with R1. On [DATE] at 11:35 AM, V11 (Agency Nurse) and stated, I just remember that I was called by the CNA I don't remember who was the CNA. I was told that (R1) struck (R2) in the face. I did not witness it. After the incident (R2) had seizures. I was with (V10) and she contacted the Nurse Practitioner. I don't know who (V10) contacted. I don't remember if I did an assessment on (R2). I would have documented the assessment in the progress noes if I did. The facility's Seizures policy (no date) documents: Initial and ongoing clinical assessments will determine the potential of seizure activity. Nursing Intervention: When seizure is over obtain vital signs (Auxiliary temperature) and position onto side. Notify physician and follow orders. Administer CPR if breathing ceases - call 911. Document findings and observations in the resident's clinical record including notification of physician and responsible party.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review, the facility failed to follow R3's care plan to apply Bilateral Palm Protectors due to actual contracture. This failure affected one (R3) of three residents reviewed for improper nursing care. Findings include: R3's admission record showed initial admitted [DATE], with diagnoses not limited to Chronic respiratory failure, Encounter for attention to tracheostomy, Dependence on respirator [ventilator] status, Encounter for attention to gastrostomy, Heart failure, Epilepsy, Anoxic brain damage, Hypoxic ischemic encephalopathy, Pressure ulcer of sacral region stage 4, Hypertensive heart disease with heart failure, Neuromuscular dysfunction of bladder, Contracture of muscle multiple sites, Pneumonia. R3's record showed hospitalization on [DATE], and readmitted on 1/16/25. R3's MDS (Minimum Data Set), dated 1/7/2025, showed R3's cognition was severely impaired. She needed total assistance / dependent with oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing. MDS showed impairment on both sides of upper and lower extremities. Care plan, dated 10/13/2024, documented: R3 Would benefit from Bilateral Palm Protectors due to actual contracture related to: Immobility and Vent support due to chronic respiratory failure. Care plan interventions included but not limited to Apply Bilateral Palm Protectors. R3's order summary report, dated 1/26/25, with active order not limited to: Apply Bilateral Palm Protectors. Apply Bilateral Palm Protectors in the morning. Release during ADL care and exercise, check for skin integrity and circulation. Perform range of motion to bilateral hand (wrist and fingers) before and after application. Remove before PM care. R3's restorative contracture observation, dated 10/13/24, showed R3 has limitations in range of motion. Severe contracture and displays less than 50% of normal range on left shoulder, left and right elbow, wrist, and hand. On 1/26/25 At 9:38 AM, R3 was observed lying in bed, on moderate high back rest, non-verbal, with tracheostomy attached to ventilator machine. R3's both hands were contracted, left hand with palm protector. Right wrist with inward contracture, no device in place, fingernails were uneven, overgrown, and touching the palm. On 1/26/25 At 10:46 AM, V13 (Restorative Director) stated R3 has contractures on both hands, and she is supposed to wear bilateral palm protectors. He said not sure why R3 did not have palm protector on right hand. On 1/26/25 At 11:46 AM, V2 (Director of Nursing / DON) stated she has been working in the facility for 2 years. V2 stated splints should have an order, be care planned, and applied properly to resident. V2 said the purpose of splint / device is to prevent contracture or prevent further contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/25 At 12:06 PM, V13 (Restorative Director, Licensed Practical Nurse/LPN) stated he has been working in the facility for almost 5 years. He stated R3 has contractures on both hands, and she uses bilateral palm protectors to prevent fingers or hand to completely close or to prevent further contractures. He said bilateral palm protectors should be applied by staff to R3 every day and off during ADL care. He stated if it is not being applied as ordered, it could potentially cause further contractures. Facility's application of splints policy (undated) documented in part: To properly apply a splint for support, comfort, or aid in contracture.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review, the facility failed to follow R3's plan of care to ensure additional tracheostomy tube at bedside for an emergency. This failure could potentially affect one (R3) of three residents reviewed for improper nursing care. Findings include: R3's admission record showed initial admitted [DATE], with diagnoses not limited to Chronic respiratory failure, Encounter for attention to tracheostomy, Dependence on respirator [ventilator] status, Encounter for attention to gastrostomy, Heart failure, Epilepsy, Anoxic brain damage, Hypoxic ischemic encephalopathy, Pressure ulcer of sacral region stage 4, Hypertensive heart disease with heart failure, Neuromuscular dysfunction of bladder, Contracture of muscle multiple sites, and Pneumonia. R3's record showed hospitalization on [DATE], and readmitted on 1/16/25. R3's MDS (Minimum Data Set), dated 1/7/2025, showed R3's cognition was severely impaired. Care plan date, initiated on 5/22/20, documented: R3 has a tracheostomy and ventilator due to chronic respiratory failure. Care plan interventions included but not limited to Keep an additional tracheostomy tube (same size as the resident's) at bedside for an emergency situation. TUBE OUT PROCEDURES: Keep extra trach tube and obturator at bedside. If same size tube cannot be reinserted, then try smaller size tube. Monitor/document for signs of respiratory distress. If smaller size tube cannot be reinserted and patient cannot spontaneously breathe, then cover stoma with gauze and use ambu bag with mask to ventilate. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help immediately. R3's care plan, dated 6/9/2020, documented: Is Ventilator dependent related to Respiratory Failure. Care plan interventions included but not limited to Maintain spare trach at the bedside. On 1/26/25 At 9:38 AM, R3 was observed lying in bed, on moderate high back rest, non-verbal, with enteral feeding hanging on the pole at bedside, with tracheostomy attached to ventilator machine, with indwelling urinary catheter. R3's trach site with dry gauze secured with tie. R3's both hands were contracted. On 1/26/25 at 9:41AM, V14 (Respiratory Therapist/ RT) stated he has been working in the facility for 2 years. He stated R3 opens eyes only, nonverbal, not able to make needs known to staff, totally dependent to mechanical ventilator, and no plan of weaning. V14 said R3 has a lot of secretions and tracheal suctioning is done at least every 2 hours and as needed. V14 said R3's tracheal stoma / opening is big; it was done during her surgery. At times, secretions are coming out from the big stoma. He said trach care is done every shift and as needed. V14 stated R3 is using bronchodilator nebulization every 4 hours. V14 was asked for spare tracheostomy tube, and did not find at bedside. V14 stated there should always be a spare trach at bedside in case of emergency; when trach was accidentally pulled out there is something to use to keep the airway patent. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/25 At 11:46 AM, V2 (Director of Nursing / DON) stated she has been working in the facility for 2 years. V2 said staff are expected to place and keep spare Tracheostomy tubes at bedside in case of an emergency. V2 stated spare trach should always be available and readily accessible during emergency in case trach tube may become dislodged or blocked that may lead to sudden loss of airway. She said spare trach tubing at the bedside is essential to quickly re-establish the airway. Facility's respiratory care program overview (undated) documented: A comprehensive respiratory care program is important in caring for residents who require comprehensive respiratory care due to respiratory care due to respiratory failure, ventilator support, tracheostomy. It is the policy of this facility to follow respiratory care practices. The goals of the respiratory care program is to provide the highest quality respiratory care in a timely, effective, safe, and efficient manner in order to decrease complications related to respiratory needs and care. This facility will accomplish this through: Active participation in the formulation of the plan of care considering the resident's needs and personal preferences. Maintain compliance with state and federal regulations relating to respiratory care.