

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Elevate Care Chicago North		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061</p> <p>Based on observation, interview, and record review, the facility failed to provide timely incontinence care for four dependent residents (R1, R4, R5, R9) reviewed for improper nursing care.</p> <p>Findings include:</p> <p>1. R1's Admission Record documents in part diagnoses of difficulty in walking, lack of coordination, abnormalities of gait and mobility, spinal stenosis-cervical region, irritable bowel syndrome, and obesity.</p> <p>R1's Care Plan Report documents R1 has bowel and bladder incontinence due to generalized weakness, impaired gait/balance, shortness of breath, and physical limitations (last revised 3/12/2025). Interventions last revised on 2/06/2025 document to check for incontinence; wash, rinse, and dry perineum; change incontinence products; and change clothing as needed. R1's Care Plan Report also documents R1 had a pressure injury to right buttock and is at risk for delayed wound healing. R1 was also at risk for further alteration in skin integrity (last revised 2/06/2025). Staff were to keep R1's skin clean and dry (initiated 2/06/2025).</p> <p>On 3/18/2025 at 2:02 PM, V15 (Certified Nurse Aide-CNA) stated V15 is working with R1 four to five times a week during the morning shift (7:00 AM - 3:00 PM). V15 stated R1 was able to verbalize needs to the staff. R1 could not get up on own, and needed staff assistance with turning/repositioning in bed and incontinence care. V15 stated R1 complained about other CNAs because they didn't clean R1 right away. V15 stated sometimes V15 comes onto shift in the morning and finding R1 soiled. V15 stated most instances were with R1 sitting in feces. V15 stated R1 would be upset the previous shift didn't change R1 and R1 was waiting for a while. Facility did not have grievance forms related to R1's concerns.</p> <p>On 3/18/2025 at 2:28 PM, V16 (CNA) stated V16 took care of R1 once. R1 complained of not being changed and complained to V16 that R1 has been waiting on assigned CNA to change R1.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. R5's Care Plan Report documents R5 is at risk for alteration in skin integrity related to antibiotic therapy, diarrhea, fragile skin, immunosuppression/immunocompromised state, limited joint mobility, malnutrition, muscle wasting, noncompliance with care, poor appetite, and weight loss (initiated 3/10/2025). It also documents R5 has a pressure injury to bilateral buttocks (initiated 3/09/2025). One of the interventions include to keep skin clean and dry (initiated 3/09/2025). R5's Care Plan Report also documents R1 has bowel and potential bladder incontinence due to generalized weakness, impaired gait/balance, and pain (last revised 3/11/2025). Interventions last revised on 3/11/2025 document to check for incontinence; wash, rinse, and dry perineum; change incontinence products; and change clothing as needed after each incontinence episode.</p> <p>On 3/18/2025 at 12:54 PM, R5 was alert and oriented to person, place, time, and situation. R5 stated R5 needs staff assistance with ADL (activities of daily living) care, such as incontinence care and dressing. R5 stated sometimes CNAs provided delayed care. CNAs will answer the call light and say they will take care of it when they return, but then will take an hour to return to help me. I'll sit in my own feces for an hour or more. There's been other times where it's been like closer to a two hour wait. Those are usually in the mornings like the night shift. I would say somewhere between 4:00-6:00 AM. R5 stated there's also delayed care usually around shift change or during mealtimes.</p> <p>3. R9's Admission Record documents in part diagnoses of Parkinson's Disease, lack of coordination, abnormal posture, and weakness.</p> <p>R9's 1/29/2025 MDS (Minimum Data Set) assessment documents R9 was cognitively intact during the look back period. It also documents R9 was dependent on staff for toileting hygiene, upper body dressing, and lower body dressing. R9 also required substantial/maximal assistance with personal hygiene.</p> <p>R9's Care Plan Report documents R9 is at risk for alteration in skin related to limited mobility (last revised 4/01/2024). Intervention documents in part to provide incontinence care as needed (initiated 4/01/2024).</p> <p>On 3/18/2025 at 1:07 PM, R9's call light was on. The monitor at the nurses' station read that it's been on for at least two minutes.</p> <p>At 1:09 PM, V16 (CNA) entered R9's room to grab the lunch tray. R9 stated R9 needed incontinence care. V16 stated V16 was collecting lunch trays and will return later. R9 asked V16 what time will V16 change R9. V16 stated V16 will be back in 10 minutes and turned off R9's call light.</p> <p>At 1:14 PM, R9 was alert and oriented to person, place, and time. R9 stated soiled self just before lunch. R9 wanted to eat lunch first, but wanted to be changed now that R9 was finished with lunch.</p> <p>At 1:49 PM, R9 stated V16 has not returned to change R9. R9 stated R9 was still sitting in soiled incontinence products and linen. V16 did not return to R9's room to provide incontinence care until 2:10 PM. V16 completed R9's incontinence care at 2:25 PM.</p> <p>39779</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. R4 was admitted to the facility on [DATE], with diagnoses not limited to Abnormalities of Gait and Mobility, Reduced Mobility, Need for Assistance with Personal Care, Osteoarthritis, Morbid (Severe) Obesity due to Excess Calories, Chronic Diastolic (Congestive) Heart Failure, Obstructive Sleep Apnea, Radiculopathy, Lumbar Region, and Idiopathic Progressive Neuropathy.</p> <p>R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.</p> <p>R4's care Plan documents: Focus: R4 presents with a functional deficit in Bed Mobility due to generalized weakness, impaired gait/balance, pain, musculoskeletal impairment, impaired mobility, physical limitations secondary to Mechanical fall, Lumbar radiculopathy, OA (Osteoarthritis) and Rotator cuff injury. Focus: R4 has alteration in musculoskeletal status related to lumbar radiculopathy, OA. Interventions: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Focus: R4 has an ADL (Activities of Daily Living) Self Care Performance Deficit due to generalized weakness, impaired gait/balance, pain, musculoskeletal impairment, impaired mobility, physical limitations secondary to Mechanical fall, Lumbar radiculopathy, OSA and Rotator cuff injury. Interventions: Encourage Resident to use bell to call for assistance. Focus: R4 has bowel and bladder Incontinence. Interventions: Brief Use: uses disposable briefs. Change prn (as needed). Incontinent: Check for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.</p> <p>On 3/18/2025 at 2:50 PM, R4 was alert and oriented to person, place, time, and situation. R4 stated sometimes staff will only change R4 twice during the day. R4 stated a CNA has even told R4 CNAs were only required to change the residents once a shift. R4 stated the staff's response to call lights can take anywhere from 30 minutes to two hours sometimes. R4 stated sometimes staff will answer the call light right away, say they will let the nurse or CNA know about the requests, but the nurse or CNA won't respond for a long time, or will say that no one ever told them R4 needed them.</p> <p>On 3/19/2025 at 1:24 PM, V2 (Director of Nursing) stated, Staff are to answer call lights as quickly as possible. If the staff can't help immediately, staff are to notify the right personnel and circle back around to see that the residents' needs were met. With incontinence care, staff are to check the residents at least every two hours and provide incontinence care when requested. V2 stated having the residents wait an hour for incontinence care is not acceptable. V2 stated a reasonable amount of time is between ten to fifteen minutes</p> <p>On 03/19/25 at 10:13 AM V27 (R4's Case Manager) stated, I am (R4's(medical case manager. I talked to (V2, Director of Nursing) and (V23, Certified Nurse Assistant) was removed from caring for (R4), but (V23) was still (R4's) Certified Nurse Assistant. (V23) was assigned to (R4's) care a few more times. (V23) was assigned to (R4's) neighbor, and (R4) requested females only. (R4) said the care is not as fast and they still only changed her once a shift. (V23) said they were only required to change the residents once a shift.</p> <p>On 03/19/25 at 12:34 PM, R4 stated, In the beginning I was peeing in the diaper, and I was changed once a shift. Now I get changed twice a shift. (V23, Certified Nurse Assistant) was changing me once a shift. I requested just females to care for me. When the Certified Nurse Assistants say they will be back, they don't come back. (V23) turned off the call light.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/19/25 at 12:55 PM, V23 (Certified Nurse Assistant) stated, The last time that I was assigned to (R4) was a month ago. I gave (R4) bed baths, peri care, gave (R4) the toothpaste to brush her teeth, pulled (R4) up in bed and put barrier cream on (R4). I would change (R4) twice per shift. I changed (R4) at 10 am and then 1 pm or 2 pm. (R4) is a one person assist, and incontinent of bowel and bladder. Management told me not to go to (R4's) room anymore, but did not tell me anything, actually. Even though I did not have (R4) as a resident, I would go check the call light and will change (R4). We are short of Certified Nurse Assistants on the 3-11 pm shift. It depends if (R4) would be soaking wet with urine from the overnight shift. The night shift doesn't do anything, and (R4) would say you (V23) need to change me. On a regular day, the residents are changed 3 - 4 times during the shift.</p> <p>On 03/19/25 at 01:32 PM, V2 (Director of Nursing) stated, My expectations are for the call light to be answered as quickly as possible to see what the resident needs. The proper response is to let whoever they need know the item, and let the resident know they notified the individual, and I would circle back. The residents should be changed at a minimum to check and change every 2 hour,s and when requested. If the Certified Nurse Assistant is not doing anything, they should answer the call light immediately, or let the resident know the Certified Nurse Assistant is busy, and is there anything that they can do for them. Answering the call light in an hour is unacceptable. Answering the call light within ten to fifteen minutes is reasonable, but that is pushing it. The staff are not allowed to deny care to the residents. The residents are changed every 2 hours and not just once a shift. When the resident turns on the call light, staff should answer immediately. If available, anyone can answer the call light. (R4) requested to be changed and (V23, Certified Nurse Assistant) told (R4) residents are only supposed to be changed once a shift. I did an investigation and gave (V23) a write up and final warning based on the Union. (V23) said he did not tell (R4) that, but (R4's) roommate (R10) and (R4) both said (V23) said that per the investigation.</p> <p>Document dated 01/27/25 - 01/28/25 presented on 03/19/25 by V2 (Director of Nursing) documents: Received a call from (V27, R4's Insurance Case Manager) for (R4) regarding the care (R4) received from (V23, Certified Nurse Assistant). (V27) says that (R4) reports when (R4) puts on the call light for care (V23) told (R4) that she can only be changed once during the shift. (V23) has been removed from the care of (R4) pending investigation. Interview was conducted with (R4) and R4's roommate (R10). Both (R4) and (R10) did state that this was said when they put on the call light for care. (R10) said that she heard (V23) say, We do not do any care after 1pm. I (V2, Director of Nursing) apologized to the residents and let (R4) know that (V23) has been removed from her care. Staff member (V23) will be put on a final written warning according to the Union.</p> <p>Employee Report, dated 01/29/25, documents : Employee V23 (Certified Nurse Assistant). Employee Action/Discipline: Final Warning. Describe What Happened: Patient Care: Patient (R4) on the (floor) reported that (V23, Certified Nurse Assistant) told her (R4) that he (V23) is not able to change the residents if they ask to be changed after lunch. Patient also reported that she turned her call light on for care and (V23) kept turning it off and leaving the room.</p> <p>Facility's Call Light policy (last revised 2/02/18) documents in part: Purpose: To respond to residents' requests and needs in a timely and courteous manner. Procedural instructions include to listen to the residents' request and do not make them feel that you are too busy to help. Respond to request. If item is not available, or request questionable, get assistance from charge nurse. Return to resident with prompt reply.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility's Incontinence Care policy (last revised 4/20/2021) documents in part: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.</p>		