

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  04/24/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>50662</p> <p>Based on observation, interview, and record review, the facility failed to assess one resident (R2) for self-administration of medications. This failure affected one resident (R2) reviewed for medications.</p> <p>Findings include:</p> <p>R2's medical diagnoses include but are not limited to type 2 diabetes with hyperglycemia, chronic kidney disease stage 2, essential hypertension, major depressive disorder, long term use of insulin, and hyperlipidemia.</p> <p>R2 Brief Interview for Mental Status (BIMS) score, dated 04/02/25, is 15, which indicated R2's cognition is intact.</p> <p>R2's physician order, dated 04/09/25, documents, Creon Oral Capsule Delayed Release Particles 36000-114000 unit .Give one capsule by mouth before meals for indigestion.</p> <p>R2's physician order, dated 03/27/25, documents, Tramadol tablet 50mg (milligrams) give 1 tablet by mouth every 12 hours for moderate to severe pain.</p> <p>On 04/21/25 at 12:13pm, R2 removed two pill bottles from R2's top drawer. R2 opened one pill bottle Creon and ingested one pill. R2 showed surveyor both pill bottles. First pill bottle observed was Tramadol 50mg (milligrams) per tablet. Second pill bottle observed was Creon 36000-114000-unit capsules.</p> <p>On 04/21/25 at 12:13pm, R2 stated he has medication in his drawer because the facility went days without giving him his medications. R2 stated due to him not getting his medications as ordered, he was in pain, and experienced vomiting and diarrhea. R2 stated he did not want to have that experience again, so he went to get his own medications.</p> <p>On 04/21/25 at 2:11pm, V19 (Licensed Practical Nurse/LPN) removed R2's medication from R2's top drawer.</p> <p>On 04/21/25 at 2:11pm, V19 (Licensed Practical Nurse/LPN) stated R2 does not have a physician's order to self-administer medication. V19 stated tramadol is a controlled substance, and should not be at R2's bedside.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/22/25 at 11:05am, V21 (Nursing Supervisor) stated residents have to have an assessment done before they are allowed to self-administer medications. V21 stated a resident self-administering medication without an assessment could lead to dosing errors.</p> <p>On 04/22/25 at 1:35pm, V2 (Director of Nursing/DON) stated residents should not self-administer medication unless they have the proper assessment and/or paperwork in place. V2 stated a resident could over medicate themselves, or other residents in the facility could get a hold of their medications and misuse the medication.</p> <p>On 04/23/25 at 11:59am, V4 (Registered Nurse/RN) stated there was a time when she informed R2 she did not have his medication, and R2 informed her he had his own medication.</p> <p>Review of R2's physician orders show no order for medication self-administration.</p> <p>Review of R2's care plan shows no care plan documented for medication self-administration.</p> <p>Facility's policy titled Self-Administration of Medication, dated 04/2014, documents, Purpose: To establish guidelines concerning the self-administration of drugs .General Guidelines: 1. A resident may not be permitted to administer or retain any medications in his/her room unless so ordered, in writing by the attending physician.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>45346</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for 1 resident (R3) out of 3 residents reviewed for call lights.</p> <p>Findings include:</p> <p>R3's diagnosis includes but are not limited to end stage renal disease, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus with hyperglycemia, acute respiratory failure, unspecified whether with hypoxia or hypercapnia, dysphagia, oropharyngeal phase, encephalopathy, unspecified, epilepsy, unspecified, not intractable, without status epilepticus, hyperlipidemia, aphasia, pressure ulcer of sacral region, unstageable, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and other lack of coordination</p> <p>R3's care plan documents, Focus: R3 has alteration in musculoskeletal status related to joint stiffness. Intervention: Be sure call light is within reach and respond promptly to all requests for assistance. R3 has potential risk for falls due to generalized weakness, impaired gait/balance, SOB (shortness of breath), impaired mobility secondary to respiratory failure, DM (diabetes mellitus) CVA (cerebral vascular accident), seizure, dementia, ESRD(end stage renal disease), anemia, and encephalopathy. Intervention: Be sure call light is within reach and encourage resident to use it for assistance as needed.</p> <p>On 4/21/2025 at 11:11am, R3 was sleeping in bed. Head of bed elevated. Bed in the lowest position. R3's call light cord was on the floor behind the head of R3's bed.</p> <p>On 04/21/2025 at 11:29am, V3(LPN/Licensed Practical Nurse) was asked where is R3's call light located, and V3 stated the call light is on the floor behind R3's bed. V3 picked up R3's call light cord from off the floor, and stated the call light should not be back there (referring to the floor behind R3's bed). V3 clipped the call light cord to R3's bed sheet.</p> <p>On 4/22/2025 at 12:34pm, V9(LPN/Licensed Practical Nurse) stated the purpose of the call light is for the residents to use when they need assistance. V9 stated the call light should be located within the resident's reach.</p> <p>On 4/22/2025 at 1:24pm, V2(DON/Director of Nursing/RN/Registered Nurse) stated the purpose of the call light is for residents to use when the resident needs something. V2 stated the call light is to be within the resident's reach. V2 stated, It is my expectation that each resident has access to the call light.</p> <p>On 4/23/2025 at 10:18am, V23(LPN/Licensed Practical Nurse) stated, The purpose of the call light is so that the resident can call us, and we can attend to the patient's needs. The call light should be within reach of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled Call Light, with a revision date of 2/2//18, documents: 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable location.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>45346</p> <p>Based on observation, interview, and record review, the facility failed to date the oxygen tubing per facility policy for two residents (R3 and R4) in a sample of three residents reviewed.</p> <p>Findings include:</p> <p>1. R3's diagnosis includes but are not limited to end stage renal disease, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus with hyperglycemia, acute respiratory failure, unspecified whether with hypoxia or hypercapnia, dysphagia, oropharyngeal phase, encephalopathy, unspecified, epilepsy, unspecified, not intractable, without status epilepticus, hyperlipidemia, aphasia, pressure ulcer of sacral region, unstageable, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and other lack of coordination.</p> <p>R3's MDS (Minimum Data Set) Section O., dated 04/13/2025, documents, 00110.Special Treatments, Procedures, and Programs, Respiratory Treatments C1. Oxygen Therapy b. While a resident.</p> <p>R3's Physician Order Summary Report, dated 04/22/25, documents, Oxygen at 2 liters/(minute) via nasal cannula; continuous for SOB (shortness of breath) every shift. Change oxygen tubing, ear protective cushions, humidifier bottle, and plastic holding bag for oxygen tubing every night shift every Thursday.</p> <p>R3's care plan documents, Focus: Has oxygen therapy. Intervention: Change oxygen tubing and humidifier every night shift on Sunday.</p> <p>On 4/21/2025 at 11:11am, R3 was sleeping in bed. Head of bed elevated. Observed oxygen concentrator machine set at 2 liters of oxygen, nasal cannula secured in R3's nares. The oxygen tubing was not dated.</p> <p>2. R4's diagnosis includes but are not limited to chronic kidney disease, stage 3a, type 2 diabetes mellitus with hyperglycemia, obstructive sleep apnea, unspecified atrial fibrillation, cardiomyopathy, major depressive disorder, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, and constipation, unspecified.</p> <p>R4's MDS (Minimum Data Set) Section O., dated 03/22/2025, documents, 00110.Special Treatments, Procedures, and Programs, Respiratory Treatments C1. Oxygen Therapy b. While a resident.</p> <p>R4's Physician Order Summary Report, dated 04/23/25, documents, Oxygen at 3 liters/minute via NC (nasal cannula) continuous for SOB (shortness of breath) every shift. Change Oxygen tubing, ear protective cushions, humidifier bottle, and plastic holding bag for oxygen tubing every night shift every Thursday.</p> <p>R4's care plan documents, Focus: Has oxygen therapy. Intervention: Change oxygen tubing and humidifier every night shift on Sunday.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/21/2025 at 11:23am, R4 was lying in bed, alert and oriented times three. R4 was receiving oxygen via nasal cannula. R4's oxygen concentrator machine was set at three liters of oxygen. R4 stated, I do not remember how long I have been receiving oxygen. I don't know how often the staff change the oxygen tubing. R4's oxygen tubing was not dated with a date indicating when the oxygen tubing was last changed.</p> <p>On 04/21/2025 at 11:29am, V3(LPN/Licensed Practical Nurse) stated the oxygen tubing is changed once a week, and should be dated indicating when it was changed.</p> <p>On 4/22/2025 at 1:24pm, V2(DON/Director of Nursing/RN/Registered Nurse) stated the nurses are responsible for changing the oxygen tubing/setup for residents on oxygen therapy. V2 stated the oxygen tubing is changed every twenty-four to forty-eight hours. V2 stated the oxygen tubing should be dated with the date the tubing was changed.</p> <p>On 4/23/2025 at 10:18am, V23(LPN/Licensed Practical Nurse) stated the oxygen tubing is changed weekly and a date is to be placed on the tubing when changed. V23 stated, I would assume it is this facility's policy to date the oxygen tubing when the tubing is changed. I assume it is the responsibility of the night shift nurse to change the oxygen tubing when needed.</p> <p>The facility's policy, dated 12/01/2021 and titled Care and Cleaning of Respiratory Equipment, documents, Procedure: A. All disposable respiratory equipment is labeled with date when placed in use.</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50662</p> <p>Based on observation, interview, and record review, the facility failed to provide routine medications to one resident (R2) as ordered by the prescriber to meet R2's needs. This failure resulted in R2 having pain, vomiting, and diarrhea.</p> <p>Findings include:</p> <p>R2's medical diagnoses include but are not limited to type 2 diabetes with hyperglycemia, chronic kidney disease stage 2, essential hypertension, major depressive disorder, long term use of insulin, and hyperlipidemia.</p> <p>R2 Brief Interview for Mental Status (BIMS) score, dated 04/02/25 is 15, which indicated R2's cognition is intact.</p> <p>R2's physician order, dated 03/27/25, documents, Tramadol tablet 50mg (milligrams). Give 1 tablet by mouth every 12 hours for moderate to severe pain.</p> <p>R2's physician order, dated 03/27/25, documents, Creon oral capsule delayed release particles 36000-114000 unit .Give 1 capsule by mouth three times a day for indigestion.</p> <p>R2's medication administration record for Tramadol document code NA on 03/28/25, 03/29/25 and 03/31/25, which indicated that medication is not available.</p> <p>R2's medication administration record for Creon (pancreatic enzyme) document code for NA on 03/28/25 and 03/31/25, which indicated not available.</p> <p>R2's care plan, dated 04/04/25, documents, Has potential for pain or experiences pain related to gastric disorder limited mobility, osteomyelitis, MDD (major depressive disorder), chronic ulcer left heel .Will have acceptable level of pain based on the 0 to 10 scale .Medications as ordered, if ineffective, notify physician.</p> <p>Facility's document titled Packing Slip Proof of Delivery shows R2's medications were delivered on 03/28/25 at 3:29am. Proof of Delivery slip shows that Creon quantity of 100 capsules were delivered.</p> <p>On 04/21/25 at 12:13pm, R2 stated R2 did not receive his pancreatic enzyme or pain medication. R2 stated because he did not receive the medication for his pancreas, he had vomiting and diarrhea, and could not get out of bed for days. R2 stated the pancreatic enzyme lessens his stomach pain and decreases the diarrhea. R2 stated he has been keeping his medication in his drawer, and takes it when he needs it, because the nursing staff does not give him the medication when he needs it, or when he is supposed to have it.</p> <p>On 04/21/25 at 2:29pm, V18 (Nurse Practitioner/NP) stated he was not aware R2 had not received his medications. V18 stated Creon is a pancreatic enzyme. V18 stated if R2 doesn't receive the pancreatic enzyme, then R2's vomiting and diarrhea could worsen.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/22/25 at 1:35pm, V2 (Director of Nursing/DON) stated NA means not available, which means the medication was not given. V2 stated records for new admissionS are reviewed before the resident comes to the facility to assure the facility can meet the needs of the resident. V2 stated R2 not receiving his Creon medication as ordered could have caused his nausea, vomiting and diarrhea, and unnecessary pain.</p> <p>On 04/23/25 at 11:59am, V4 (Registered Nurse/RN) stated she did not give R2 his Creon medication because she couldn't find it. V4 stated she called pharmacy and was told that the medication was delivered to the facility, but she couldn't find it, so she documented the medication was unavailable. V4 stated days later, she found the medication in the top drawer of the medication cart. V4 stated the nurse that placed the order for R2's tramadol did not get a prescription signed by the nurse practitioner, so the pharmacy did not fill the prescription. V4 stated when the tramadol was scheduled, she was unable to give it because it was not available. V4 stated she had the NP sign a prescription for R2's tramadol, so that it could get filled.</p> <p>Facility's policy titled Administration Procedures For All Medications, dated 10/25/2014, documents, Policy: To administer medications in a safe and effective manner.</p> <p>Facility's undated job description titled Registered Nurse (RN) documents, Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times .Essential Duties and Responsibilities: .Prepare and administer medications as ordered by the physician.</p>		