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Form Approved OMB
No. 0938-0391

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	01/30/2026

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 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** Based on observation, interview, and record review, the facility failed to provide timely wound care for one (R1) out of three residents reviewed for wound treatment. Findings Include: R1's Electronic Health Record/EHR shows she was admitted to the facility on [DATE], she is [AGE] years old, her Brief Mental Status shows she is severely impaired. She has diagnoses not limited to chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, dysphagia oropharyngeal phase, encephalopathy, dysphagia following cerebral infarction, aphonia, and dependence on supplemental oxygen.On 1/29/26 at 10:34 AM, R1 was supine in bed, non-verbal, and she was unable to respond to interview. On 1/29/26 at 3:06 PM, V7 (Wound Care Coordinator) stated he cannot recall if anyone told him about R1's left gluteal small skin alteration on 1/23/26 until 1/27/26 when he called the doctor for a treatment order. He also stated he realizes there was a delay of treatment, which could potentially worsen R1's wound. On 1/29/26 at 2:47 PM, via telephone, V11 (Licensed Practical Nurse/LPN) stated an unidentified Certified Nursing Assistant/CNA reported to her on 1/23/26 that R1 has small superficial skin alteration on her buttocks. She reported to the wound team, but she did not document the intervention anywhere in R1's medical record, V11 stated she knows if it is not documented that it means it was not done. On 1/29/26 at 2:50 PM, V2 (Director of Nursing/DON) stated she has been in the facility since June 2025, and it is her expectation that nurses would provide nursing interventions timely to prevent further tissue breakdown. She also stated R1's wound on her buttock is very small even though the treatment was not started until after three days. R1's Physician Order Sheet/POS active order as of 1/29/26 shows wound care, left gluteal cleanse with normal saline, apply zinc oxide paste, cover with silicone bordered foam every day and as needed (PRN) every shift dated 1/28/26. R1's Treatment Administration Record/TAR shows initial wound treatment, dated 1/27/26.R1's progress notes, dated 1/27/26, Wound Care: R1's Left Gluteal - Cleanse with normal saline, pat dry, apply Zinc Oxide paste, cover with Silicone Bordered Foam, every day and as needed/PRN.Change in condition policy, dated 7/8/24, documents: To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner.Registered Nurse and Licensed Practical Nurse Job description: documents: Ensures timely notification of medical director.

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