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	06/03/2026

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 follow physician orders by failing to perform blood glucose monitoring before meals for one resident (R1) in a sample of four reviewed.Findings include:R1 is a [AGE] year-old individual, whose current face sheet documents diagnoses including but not limited to: type 2 diabetes mellitus with unspecified complications, atherosclerotic heart disease of native coronary artery without angina pectoris, delusional disorders, major depressive disorder, recurrent, unspecified.R1's Minimum Data Set (MDS) section C-Cognitive abilities, dated 5/21/26, document R1's Brief Interview for Mental Status (BIMS) as 15/15, indicating R1 has intact cognitive abilities. Section GG - Functional Abilities documents R1 requires Supervision or touching assistance/ Partial/moderate assistance with Activities of daily living (ADL) care.R1's Physician Order Sheet (POS) dated 5/13/2026 documents:-Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 4 units subcutaneously before meals for DM (Diabetes)-and inject as per sliding scale: 151 - 200 = 2 unit; 201 - 250 = 4 unit; 251 - 300 = 6 unit; 301 - 350 = 8 unit; 351 - 400 = 10 unit inform MD if >400, subcutaneously before meals for DM.On 06/03/2026 at 12:20PM, V17 (Registered Nurse-RN) was observed on the unit in the hallway standing by her computer. V17 was asked what R1's blood glucose levels were before lunch. V17 stated she has not taken R1's blood glucose levels. V17 stated she was busy with another resident who was having issues. V17 further stated this is her second week working at the facility and does not know which residents need glucose monitoring.V16(Assistant Director of Nursing-ADON) joined in and stated she was checking on V17 to see how V17 was doing. V16 went to R1's room and found R1's lunch tray on the side table. R1 stated she was trying to eat but was in pain and needed assistance repositioning. V16 went to get R1 pain medication. At 12:36PM, R1 was observed eating her lunch and stated she was drinking her soup because she was hungry. V16 took R1's glucose levels which were 192mg/dL. V16 administered to R1 2 units of insulin Lispro per sliding scale and 4 units scheduled.V16 stated blood glucose monitoring is scheduled before meals. It gives accurate base line blood glucose levels. This documents whether the resident has low or high blood glucose levels and if resident need insulin to control blood sugar levels. Taking blood glucose levels after resident eats can give false reading which can lead to residents receiving incorrect insulin dosage.On 06/03/2026 at 1:22PM, V2(Director of Nursing) said blood glucose levels are supposed to be taken before meals because it lets the nurses know the resident's baseline before meals. Knowing the levels allows the nurses to follow physician orders and administer insulin as ordered. Risk of taking blood glucose levels after the resident has started eating is potential for blood glucose level to be elevated. This might not give a baseline for the resident and can lead to residents receiving insulin based on results taken after resident has started eating. This can affect a resident's treatment plan.V2 stated the facility does not have a policy on nurses following physician orders.

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