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	05/16/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on observation, interview, and record review, the facility failed to ensure staff provided privacy during care for 1 (R219) resident observed for resident rights in a sample of 32. Findings Include: R219 was admitted to the facility on [DATE], with diagnoses not limited to Type 2 Diabetes Mellitus with Hyperglycemia, Acute Kidney Failure, Dependence on Renal Dialysis, Gastrostomy, Hypertensive Heart Disease, Shaken Infant Syndrome, Cerebral Palsy, Epilepsy, Abnormalities of Gait and Mobility, Polycystic Ovarian Syndrome and Blindness, Both Eyes. R219's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) indicates resident is rarely/never understood. On 05/13/25 at 12:08 PM, R216 was observed from the doorway in bed. V8 (Restorative) was observed in R216's room adjusting R216's brief, with the door open, the privacy curtain open, and R216's roommate, R28, privacy curtain open. Enhanced Barrier Precaution signage was observed at R216 room entry. V8 did not have a gown on while providing care. V8 stated, (R219) has a g-(gastric) tube. I was adjusting (R216's) diaper, I should have given (R216) her privacy, and had on PPE (Personal Protective Equipment), a gown and gloves. On 05/15/25/ at 09:16 AM, V2 (Interim Director of Nursing) stated, My expectation when staff is providing care for a resident is privacy. The staff should have had the door closed or used the privacy curtain. Policy: Titled Resident Rights, reviewed 01/04/19, documents: Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: Privacy and confidentiality. Titled Incontinence Care, revised 01/26/18, documents: Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Procedure: 1. Explain procedure to resident and bring equipment to bedside. Provide privacy. Rationale/Amplification: Avoid unnecessary exposure.

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review, the facility failed to provide an specialized call light within reach for a resident with limited movement. This affected one (R56) out of six residents reviewed for call lights in a total sample of 32. Findings include: R56 has diagnoses which includes but not limited to Quadriplegia, Neuromuscular Dysfunction Of Bladder, Unspecified, Pressure Ulcer Of Sacral Region, Stage 4, Anxiety Disorder, Chronic Embolism And Thrombosis Of Other Specified Veins, Post-Traumatic Stress Disorder, Chronic, Hydronephrosis With Renal And Ureteral Calculous Obstruction, Hypokalemia, Unspecified Protein-Calorie Malnutrition, Iron Deficiency Anemia, Constipation, and Encounter For Attention To Ileostomy. R56's MDS (Minimum Data Set), dated 01/23/25, documents intact cognitive function. MDS, dated [DATE], documents R56's primary medical condition is Traumatic Spinal Cord Dysfunction and impairment in range of motion on both sides of upper/lower extremities and dependency on staff to perform all ADLs (Activities of Daily Living) and transfer. R56's comprehensive care documents R56 has a ADL self-care performance deficit due to generalized weakness, musculoskeletal impairment secondary to quadriplegia and includes intervention to encourage R56 to use bell to call for assistance. R56's comprehensive care plan also contains focus for fall risk and includes intervention be sure call light is within reach and encourage resident to use it for assistance as needed. On 05/15/25 at 7:58 AM, R56 was lying in bed. Call light was on the floor under R56's bed. R56 stated he cannot reach the call light, and he cannot use that type of call light with his hands because he cannot press the button on it with his fingers. R56 stated he is paralyzed. R56 stated he used to use a blow call light (air activated call device) when he was living in a different unit/room, but when he was readmitted from the hospital, he was readmitted to this room, and since then he has not had any call light he can use. R56 stated when he needs help from the staff, he will yell for the Certified Nursing Assistant (CNA) and if they do not come, he will try to use his cell phone to call for help, but the staff does not always answer the phone. When this happens, he just has to wait until someone checks on him, which sometimes takes a long time, especially at night. R56 stated he used to use the air activated call light and wants it back, because that is the only type of call light he can consistently use and get a response from staff. On 05/15/25 at 8:01 AM, V19 (Registered Nurse/Nursing Supervisor) observed R56's call light on the floor, picked it up off the floor, and put the call light within R56's reach. V19 stated R56 has a call light, but it was on the floor, and he could not reach it. V19 stated the call light should be within R56's reach. R56 told V19 that he cannot use that type of call light because he cannot press the button on it. V19 stated R56 should have a call light that he can use which accommodates his disability. V19 stated it is important for R56 to have access to a call light, so that he can call for help and receive the care he needs when he needs it. V19 stated even though R56's room is next to the nursing station and R56 has access to a phone, R56 having access to a call light which R56 can use is a priority, and should be provided to him. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 8:16 PM, V2 (Interim Director of Nursing) stated, The purpose of the call lights is so the residents can call for assistance when needed. Call lights should be located within reach of the resident. The facility needs to accommodate the resident needs, so if they are unable to use the traditional call light, then the facility would provide that resident(s) with a padded or air activated call device. The residents are rounded on every two hours, and the potential problem with the resident not having access to the call light, is the then the staff would not know if the resident needs assistance in between this two-hour period. Even though (R56) has access to his phone, and his room is near the nursing station. He should still have access to a call light he can use, so that he can request assistance as needed. The call light triggers automatically at the nursing station with an alarm sound so everyone can hear it. If (R56) is using his phone to call the nursing unit, he is dependent on a staff picking up the phone at the nursing station to answer the call, so if no one picks up the phone, he potentially will not get the help he needs. Facility provided policy titled, Call Light, dated 02/02/18, which documents the purpose is to respond to residents' requests and needs in a timely and courteous manner and guidelines include but not limited to, 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 and hand bells will be provided for alert dependent residents when positioned out of reach of permanent call light when needed. Facility provided document titled, Residents' Rights for People in Long-Term Care Facilities - Illinois Long-Term Care Ombudsman Program dated 11/18 which documents in part, your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life and your facility must provide equal access to quality of care regardless of diagnosis, condition and your rights to safety include facility must be safe, clean, comfortable and homelike.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record review, the facility failed to refer residents to the appropriate state designated authority for re-screening and Level II referral. This failure affects three residents (R17, R84, R93) out of five residents reviewed for Preadmission Screening and Annual Resident Review (PASARR) in a total sample of thirty-two. Findings Include: 1. R84's Minimum Data Set (MDS), dated [DATE], shows R84 is moderately cognitively intact. R84's face sheet shows she is [AGE] years old, initially admitted to the facility on [DATE] with diagnoses of bipolar disorder current episode depressed, severe with psychotic features. There is no documentation to show R84 was referred to the appropriate state-designated authority for Level 2 PASARR evaluation and determination. On 5/14/25 at 1:52 PM, surveyor asked V24 (Social Services Consultant) for a Level 2 PASARR screening for R84; she provided the surveyor with an omnibus budget reconciliation act (OBRA) initial screening dated 12/15/20. V24 stated R84 was not revaluated since (assessment company) took over two years ago. V24 has no Level 2 PASARR for R84. V24 was unable to provide a level 2 PASARR, and the facility does not have PASSAR policy. On 5/15/25 at 11:00 AM, V24 provided R84's level 1 PASSAR, dated 5/14/25. 46342 2. R93 admitted to the facility 11/17/21. R93's diagnoses includes Schizoaffective Disorder, Bipolar Type, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, and Anxiety Disorder. R93's Order Summary Report, dated 05/14/25, documents Duloxetine for Bipolar, Hydroxyzine for Anxiety Disorder, Seroquel for Schizoaffective Disorder. R93's MDS (Minimum Data Set), dated 03/16/25, indicates R93 has intact cognition. R93's OBRA (Omnibus Budget Reconciliation Act) Initial Screen, dated 11/12/21, documents no the individual has (not) been formally diagnosed with a mental illness verified by a DSM-IV classification which substantially impairs the person's cognitive, emotional and/or behavioral functioning and no, there are (no) other indicators of mental illness. On 05/14/25 at 1:09 PM, V24 (Social Service Consultant) stated R93 had an OBRA completed when he was initially admitted , but he was not re-evaluated after (assessment company) took over the program in March 2022. V24 stated R93 should have been re-submitted to (assessment company) in March 2022 for re-evaluation, but it was not done. V24 stated she just submitted for R93 to be evaluated for PASRR I (Pre-Admission Screening & Resident Review) today. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V24 provided document titled Notice of PASRR Level I Screening Outcome, dated 05/14/25, documents suspected or confirmed PASRR condition (MH) mental health disability and refer to Level II onsite. V24's PASRR Outcome Explanation documents the PASRR Level I screen shows that you need a face-to-face Level II evaluation and PASRR Level I screen and Level II evaluations are required by Federal law, 42 U.S. C. 139(e)(7). You need this evaluation because you may have serious mental illness and the purpose of this evaluation is to decide whether a nursing facility is able to meet your needs. 39779 3. R17 was admitted to the facility on [DATE], with diagnoses not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Generalized Anxiety Disorder, Contracture of Muscle, Left Hand, Major Depressive Disorder, Recurrent, Moderate, Epilepsy, Migraine, Muscle Spasm, Hypertensive Heart Disease, Hyperlipidemia, Anemia, Delusional Disorders, Monocular Exotropia, Right Eye, Cognitive Communication Deficit, Long Term (Current) use of Anticoagulants, Chronic Embolism, and Thrombosis of Unspecified Vein. R17's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 14, indicating intact cognitive response. R17's Interagency Certification of Screening Results, dated 04/23/19, document: Screening indicated nursing facility services are appropriate. R17's OBRA (Omnibus Budget Reconciliation Act) 1 Initial screen dated 04/23/19. R17's Notice of PASRR Level I Screen Outcome, dated 05/15/25, documents: Suspected or confirmed PASRR Condition(s): (MH) Mental health Disability. This screen shows that you need a face-to-face Level II evaluation. You need the evaluation because you may have serious mental illness or an intellectual/developmental disability. Reason for Screening: This nursing facility resident has never had a PASRR Level I screen. Ascend Outcome: Rationale: A PASRR Level II evaluation must be conducted. On 05/14/25 at 01:50 PM, V24 (Social Service Consultant) stated (assessment company) was not a thing until 2022. I can create a request for (R17). (R17) had an OBRA and was admitted in 2019. On 05/14/25 at 03:26 PM, V24 (Social Service Consultant) presented the surveyor with a form titled PASRR (Preadmission Screening and Resident Review) Pro-I. PASRR Level 1 Screen, dated 05/14/25. V24 stated I have worked here as the consultant since June or July of 2022. I was made aware of the PASRR, but I cannot recall the exact date. It should be done if there is a change in condition, a new diagnosis, for everyone with a suspicion of a mental illness and prior to admission.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on observation, interview, and record review, the facility failed to provide one to one feeding assistance and properly position a resident in bed consistent with the plan of care during meals. This deficient practice was observed for 1 (R28) resident observed during the dining task in a sample of 32. Findings include: R28 was admitted to the facility on [DATE], with diagnoses not limited to Dementia, Flaccid Hemiplegia Affecting Left Nondominant Side, Dysphagia, Oropharyngeal Phase, Type 2 Diabetes Mellitus with Hyperglycemia, Epilepsy, Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Stage 3, Depression, Anxiety Disorder, Hypertensive Heart Disease with Heart Failure, Unspecified Intellectual Disabilities, and Gastro-Esophageal Reflux Disease. R28's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 03, indicating severe cognitive impairment. R28's Care Plan documents: Focus: R28 requires a Mechanically Altered Diet r/t (related to) dysphagia. Per nurse, resident C/O (complain of) difficulty swallowing & coughing / choking w/ (with) medication. Diet: general, pureed. Interventions: Position head of bed up for meals. Date Initiated: 12/30/19. 1:1 feeding assistance Date Initiated: 04/19/24. Monitor Intake Date Initiated: 12/02/21. Monitor during mealtime. Date Initiated: 12/02/21. Monitor for signs and symptoms of aspiration or choking. Continue supervision to maximize PO (by mouth) intake. Focus: R28 presents with impaired ability to feed self-due to impaired cognition. Desired Outcome: R28 will receive hands on staff assist during meals to stimulate adequate meal completion. Interventions: Ensure appropriate positioning to facilitate safe swallowing. Give verbal cues and hands on assist as needed to resident while eating. R28's Order Summary Report documents: Consistent Carbohydrate, No added salt diet Pureed texture. Nectar Consistency. Pleasure feed diet. R28's MDS Section G -Functional Ability A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. (02) Substantial/maximal assistance - Helper does more than half the effort. Helper lifts and holds trunk or limbs and provides more than half the effort. On 05/13/25 at 12:21 PM, R28 was observed in bed at a 45-degree angle, attempting to eat a pureed diet, unassisted by staff. R28's left hand was observed to be flaccid and laying on the bed. On 05/13/25 at 12:28 PM, V9 (Agency Licensed Practical Nurse) stated, It looks like (R28) is feeding herself at a 45-degree angle. It looks like she (R28) should come up. V9 went to the side of R28's bed, picked up the bed control, and elevated the head of R28's bed. V9 then said (R28) is now at a 90-degree angle. V9 was asked what could potentially happen when R28's head of the bed was at a 45-degree angle while eating. V9 responded, (R28) could aspirate on her food and choke. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 09:16 AM, V2 (Interim Director of Nursing) stated, (R28) should be in an upright position while eating. If (R28) was at a 45-degree angle while eating, she could aspirate. On 05/15/25 at 09:40 AM, V13 (Restorative Director) stated, When we do the quarterly assessment, we add new interventions as appropriate. (R28) is a 1:1 feeder, but it depends on the day because sometimes (R28) is able to feed herself. Most of the time the staff have been feeding (R28). Since (R28's) care plan intervention has 1:1 feeder, (R28) should be a 1:1 feeder. When a resident is eating while in the bed, they should be in an upright position when being fed and eating to prevent aspiration. Policy: Titled Feeding and Assisting Residents to Eat, undated, documents: Purpose: To assist the resident to obtain nutrients and hydration. Procedure: 3. Assist resident to comfortable position, 60 degrees - 90 degrees. Titled Restorative Nursing Program, revised 01/04/19, documents: Purpose: To promote each resident's ability to maintain or regain the highest degree of independence as safely as possible. Includes, eating and swallowing. Each resident involved in a restorative program will have an individualized program with individualized goals and measurable objectives documented on the plan of care. Develop and individualized program based on the resident's restorative needs and include the restorative program on the care plan. A functional maintenance program may include range of motion provided during routine daily care such as dressing, grooming/hygiene, eating, transfers bathing etc.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to ensure communication assistive materials were readily accessible for a resident (R67) who speaks a foreign language, and failed to provide communication tools or communicate with one resident (R161) who has communication deficit out of three residents reviewed in a final sample of 32. Findings Include: 1. R67's clinical records show an admitted [DATE]. R67s Minimum Data Set, dated dated [DATE], shows R67's preferred language is Urdu. R67's communication care plan shows R67 presents with an alteration in ability to communicate related to speaking a foreign language. On 5/13/25 at 12:49 PM, R67 was observed in bed alert and verbally responsive. V37's (R67's Family Member) was at bedside, visiting. Surveyor attempted to interview R67 and V37. R67 stated, Urdu. No English. Surveyor asked and gestured if R67 has communication board to use to communicate in English, but R67 was unable to understand. Surveyor could not find any type of communication board or binder in R67's room to communicate with R67. On 5/13/25 at 12:55 PM, V12 (Licensed Practical Nurse) stated she calls R67's family member to communicate with R67. V12 stated she is not sure if there is any staff in the facility that speaks R67's language. V12 did not answer when asked what they do if no family member is available to translate for R67. 45111 2. R161's current face sheet documents his medical diagnoses includes but not limited to: dysphagia, oropharyngeal phase, type 2 diabetes mellitus with diabetic chronic kidney disease, anoxic brain damage, not elsewhere classified, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, and end stage renal disease. Minimum Data Set (MDS) Section C - Cognitive Patterns, dated 4/8/25, does not document R161's Brief Interview for Mental Status (BIMS) score. MDS Section GG - Functional Abilities documents R161 is dependent on staff for all ADL (Activities of Daily Living) care. On 05/13/2026 at 12:20PM, R161 was observed laying in bed awake, bed in low position, floor mats in place. V4 was observed in R161's room hanging his nutritional supplement, and R161 was observed trying to communicate with V4, but his words were not coming and were not coming out loud. He was speaking very slowly. R161 was observed making facial grimaces and crying. V4 finished hanging the nutritional supplement, and asked R161 what he was trying to say. V4 stated she could not understand R161, and left the room saying, Let me ask (V10, Certified Nursing Assistant) what you are saying because I cannot understand you. V4 left the room and did not return. R161 was asked what was wrong and if he needed help. R161 very softly and slowly explained he was experiencing back pain. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2026 at 12:38 PM, V4 was in the hallway standing by her medication cart. V4 was asked if she found out what R161 was trying to communicate to her. V4 stated she could not find V10, therefore, she did not go back to R161's room because she cannot understand him. 05/13/2026 at 12:40 PM, V2(Interim Director of Nursing), and V4 went to R611's room and found R161 crying, and when asked by V2 what was wrong, R161 very slowly and softly stated he was having back pain. V2 stated V4 should have used a communication board to communicate with R161, or taken the time to understand what R161 was trying to communicate, so that his needs are met. V4 stated there is no communication board, and she had not seen one by the nursing station. On 05/15/2025 at 11:13AM, V6(Social Services Director) stated residents are screened for communication needs during the initial assessment upon admission to the facility. V6 stated there is a communication line(phone) at the nursing station that nurse call for interpreter services. V6 further stated there is communication /letter board in the Social Services office to be used with residents who have difficulties. If determined a resident needs a communication board, to communicate their needs, the communication board is kept in the resident's room. V6 stated she has not interacted with R161 a lot, but she knows he goes to speech therapy. V6 stated it is important for residents with communication deficits to be provided a way of communicating with staff so they can communicate their needs. On 05/15/2025 at 11:24AM, V29 (Speech Pathologist) stated R161 can communicate using a few words, can answer questions, and is able to communicate when he is hungry, in pain, or has other needs. V29 stated R161 is very clear and understandable communicating his need, although he has a very quiet voice, but anybody can understand him if they pay close attention to what he is saying. V29 stated R161 is in speech therapy to help his voice get stronger, but his speech is very clear. V29 stated if asked a question, R161 understands and answers questions, but in a very soft voice. V29 stated when talking to R161, staff need to be patient so that they can hear what R161 is saying. V29 stated R161 is not able to use the communication board effectively because he closes his eyes and does not keep them open for a long time. Even when he is awake, he will respond even when his eyes are closed, and his speech is very understandable if someone takes to time to listen to him. V29 stated staff need to pay close attention to residents who have speech deficits so that their needs are not overlooked. Policy titled Language Assistance Services, no date: -It is the policy of this facility to offer language assistance services to all residents who are determined to have a language or communication barrier

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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** 39779 Based on observation, interview, and record review, the facility failed to provide Peripherally Inserted Midline Catheter care for 1 (R66) resident reviewed for Midline care and failed to manage one residents (R112) low blood pressure, for 2 of 7 residents reviewed for quality of care in a sample of 32. Findings Include: 1.R66 was admitted to the facility on [DATE], with diagnoses not limited to Cerebral Palsy, Rheumatoid Arthritis, Chronic Pain Syndrome, Depression, Anxiety Disorder, Urinary Incontinence, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Right Lower Extremity, Neuromuscular Dysfunction of Bladder and Anemia. R66's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response. R66's Oder Summary report documents: Midline IV catheter - change catheter dressing every night shift every 7 days for IV therapy R66's MAR (Medication Administration Record), dated 05/01/25 - 05/31/25, documents: Midline IV Catheter - Change Catheter Site Dressing every night shift every 7 day(s) for IV Therapy -Start Date- 04/29/25 2300. Signed on 05/06/25 by V12 (Licensed Practical Nurse). Licensed Practical Nurse Job Description, undated, has no documented duties or responsibilities for caring for or changing the Midline dressing. On 05/13/25 at 12:59 PM, R66 was observed lying in bed, with a single lumen Midline in place to the left arm, with an unlabeled/dated transparent dressing in place. R66 stated, (V11, Infection Preventionist/Registered Nurse) said that he was going to change the dressing today. The dressing was changed on 05/02/25, there was a date on it, but it fell off. I was receiving antibiotics and the last date I received the antibiotics was on 05/05/25. An empty IVPB (intravenous piggyback) bag labeled Meropenem, dated 05/05/25, was observed hanging on an IV pole near the foot of R66's bed. On 5/13/25 at 3:21 PM, V11 (Infection Preventionist/Registered Nurse) stated, (R66) has a Midline, and the dressing is changed on a weekly basis. When asked should the dressing be labeled and dated, V11 responded, It has a strip that has the date. V11 was informed R66 said the dressing was changed on 05/02/25. V11 said, If the dressing was changed on 05/02/25, it should have been changed on 05/09/25. (R66) did come to me, and I said that I could change the dressing. If the dressing is not changed there is a potential for infection, blood infection. On 05/14/25 at 09:51 AM, R66 was observed in R66's bedroom in a wheelchair. R66 stated, My IV dressing was changed yesterday (05/13/25). (continued on next page)

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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 05/14/25 at 11:51 AM, V4 (Licensed Practical Nurse) stated, When a resident receives IV antibiotics, the Licensed Practical Nurse can hang the bag. If starting a peripheral line, the LPN needs a certificate. The Registered nurse change the peripheral lines and change the Midline/PICC (Peripherally Inserted Central Catheter) Line dressings. On 05/14/25 at 2:11PM, V11 (Infection Preventionist/Registered Nurse) was asked are Licensed Practical Nurses allowed to change Midline/PICC Line dressings. V11 responded I don't believe it is in their scope. The Licensed Practical Nurse needs a special certification to put in an IV line. On 05/14/25 at 02:41 PM per telephone interview, V12 (Licensed Practical Nurse) stated I am not responsible for changing the Midline/PICC line dressings. That is not the responsibility of a Licensed Practical Nurse. On 05/06/25, I did not change (R66's) Midline dressing. V12 was informed her (V12's) initials were on the MAR (Medication Administration Record), dated 05/06/25. V12 responded That was my mistake. With a peripheral line, we check for redness and swelling, and call the supervisor to look at it. We are allowed to hang IVPB (antibiotics), but we are not allowed to start a peripheral line or change the dressing for a PICC or Midline. On 05/15/25/ at 09:16 AM, V2 (Interim Director of Nursing) stated, If a resident has a Midline the Registered Nurse is responsible for the care of the Midline, changing the dressing on a weekly basis or as needed, monitor for signs and symptoms of infection. The Licensed Practical Nurses are not supposed to change the Midline dressing. When the dressing is changed it should be labeled with the nurse initials and date. If the Midline dressing is not changed as scheduled there is a risk for infection. When the Midline dressing is changed the nurse signs out on the MAR (Medication Administration Record. Policy: Titled Central Venous Catheter Dressing Changes, revised 09/01/16, documents: Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter-related infections that are associated with contaminated, loosened, soiled or wet dressings. Preparation: 1. Verify with State Nurse Practice Act the scope of practice for Rn's (Registered Nurses) and LPN's (Licensed Practical Nurses) regarding this procedure. General Guidelines: 5. [NAME] transparent semi-permeable membrane dressing every 5-7 days and prn (as needed). Documentation: 1. The following information should be recorded in the resident's medical record. a. Date and time dressing was changed. h. Signature and title of the person recording the data. 45111 2. R112's current face sheet documents her medical diagnoses includes but not limited to: Malignant neoplasm of the rectum, hypokalemia, dysphagia, oropharyngeal phase, cellulitis of buttocks, and anemia, unspecified. Minimum Data Set (MDS) Section C - Cognitive Patterns, dated 4/23/25 documents R112's Brief Interview for Mental Status (BIMS) score as 12/15, indicating R112 has moderate cognitive impairment. MDS Section GG - Functional Abilities documents R112 requires set up or clean up assistance with eating and oral hydyne, supervision or touching assistance with upper body dressing, partial to moderate assistance with toileting hygiene, shower/bathing self, putting on/taking off footwear and lower body dressing. R112 is dependent on staff for personal hygiene. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2025 at 12:10PM, R112 was observed laying in bed, was alert and oriented to person, place, time, and situation/ and stated she was laying in bed because her blood pressure was taken this morning by V4(licensed Practical Nurse-LPN) and it was low. R112 stated, (V4) took the blood pressure again about 9:00AM, and it was still low at 93/47. (V4) has not been back and nothing has been done since then. R112 stated she was feeling weak, tired, and sleepy, and stated, I am going to die in here if (V4) does not come to check my blood pressure and see where it is now. On 05/13/2025 at 12:13PM, V4 was observed going into R112's room with a blood pressure machine, and took R112's blood pressure which registered 81/37, heart rate: 39. V4 stated she should have checked R112's blood pressure earlier because it was low, even after giving medications to raise it up. V4 stated 112's blood pressure should be at least 100/70, and R112's low blood pressure can lead to her passing out. V4 further stated she should have notified the doctor that R112's blood pressure was still low after giving the medication. R112's blood pressure readings document: 05/13/2025 at 13:17 PM 73/35mmHg 05/13/2025 at 12:36 PM 84/47 mmHg 05/13/2025 at 0:9:17 AM 93/47 mmHg 05/13/2025 at 0:7:45 AM 97/30 mmHg On 05/15/2025 at 10:06AM, V2(Interim Director of Nursing-DON) stated after V4 took R112 blood pressure and it was low, V4 should have checked R112's blood pressure again in 30-40 minutes to see if her blood pressure was going up and getting better. V2 stated if the medication was not working, V4 is supposed to notify the physician for orders to manage R112's low blood pressure, because if no interventions are taken, R112 can go into hypovolemic shock and pass out (code), which can lead to health complications. R112's Physician Order Sheet (POS), dated 4/28/2025, documents: Midodrine HCL Oral Tablet 5MG(Midodrine) give 2 tablets orally every 8 hours for hypotension R112's Electronic Medical Record (eMAR) document's R112 received Midodrine HCL Oral Tablet 5MG(Midodrine) 2 tablets 5/13/2025 at 13:35 Policy titled Physician-Family Notification-Change in Condition, dated 11/13/2018, documents: -The facility will inform the resident; consult with the physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's regal representative or interested family member when there is: -(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).

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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** 44103 Based on observation, interview, and record review, the facility failed to follow physician order to ensure assistive device was applied to one (R118) resident with a left hand contracture for residents reviewed for limited range of motion in a final sample of 32. Findings Include: On 5/13/25 at 10:34 AM, R118's electronic health records show R118 was admitted in the facility on 3/7/23, with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia, Dementia, and Depression. R118's Minimum Data Set, dated dated [DATE], shows R118 is moderately impaired with cognition, and is dependent on staff's assistance on dressing, grooming, and personal hygiene. R118's physician order reads: Apply left hand palm protector at all times or as tolerated for contracture management. Check for skin irritation, redness and pain. Off during adl [activities of daily living] care and as needed (ordered on 3/13/25). R118's care plan reads: [R118] would benefit from use of Palm Protector due to he is at risk for developing/has actual contracture related to: Physical inactivity (date initiated 3/13/25) with desired outcome reads in part: [R118] will tolerate use of Palm Protector without adverse reaction daily. Program to be performed every shift daily, 6-7 days/week through next review. Type(s) of splint/brace: Palm Protector Location of application: Left Hand Application schedule: Apply at all times or as tolerated. On 5/13/25 at 11:55 AM, R118 was observed sleeping in bed, and noted with no left hand palm protector. On 5/13/25 at 12:09 PM, R118 was observed being assisted by V14 (Certified Nursing Assistant/CNA) with feeding for lunch. R118's was not able to open his left hand fingers from a closed fist. R118's left hand palm protector was not in place. V14 stated Restorative applies a device for R118's left hand, and does not know what it's called. On 5/13/25 at 3:19 PM, V13 (Restorative Director) stated residents with contractures are placed on passive range of motion exercises, and/or application of assistive device like splints of palm protectors. V13 stated it is important to follow therapy or doctor's orders in application of assistive devices to maintain the resident's current function and prevent further contracture. V13 stated R118 has left hand contracture, and his left hand palm protector is to be applied at all times, or as tolerated. V13 stated nurses and CNAs should also monitor residents' assistive devices are in place. The facility's APPLICATION OF SPLINTS (no date) documents: To properly apply for support, comfort, or aid in contracture prevention.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46342 Based on observation and interview, the facility failed to prevent urinary drainage bag from touching the floor for one (R57) out of three residents reviewed for urinary catheter in a sample of 32. Findings Include: R57 has diagnoses including but not limited to Benign Prostatic Hyperplasia, Obstructive and Reflux Uropathy, Hematuria, Chronic Kidney Disease Stage 3, Cognitive Communication Deficit, Weakness, and Abnormalities of Gait and Mobility. R57's MDS (Minimum Data Set) indicates R57 is cognitively intact and has an indwelling catheter. R57's Order Summary Report, dated 05/13/25, documents diagnosis for indwelling catheter: Obstructive Uropathy and change indwelling catheter and drainage bag as needed. On 05/13/25 at 12:18 PM, R57 was lying in bed, and urinary drainage bag was lying directly on the floor next to R57's bed. On 05/13/25 at 12:20 PM, V19 (Nursing Supervisor/Registered Nurse) observed R57's urinary drainage bag lying on the floor next to R57's bed. V19 stated, The urinary bag should not be touching the floor due to infection control concerns and to prevent infections. Microorganisms from the dirty floor can potentially get into the urine in the bag, which could potentially cause a urinary tract infection and lead to sepsis. The urinary drainage bag has a hook on it, and should be hooked to the side of the bed so that it is not lying on the floor like that. On 05/14/25 at 05:17 PM, V2 (Director of Nursing) stated, Urinary drainage bags should not be on the floor for infection control reasons. If the bag is touching the floor, the floor might be dirty, and the bag should be hooked on the side of the bed, not on the floor. It is a standard of practice for the urinary drainage bag not to be lying on the floor, and is a preventative measure to reduce infection. Facility provided policy titled, Urinary Catheter Care, dated 02/14/19, documents the purpose it to establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter and guidelines include but not limited to urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to follow a resident's care plan and physician's order to keep head of bed up to 45 degrees for a ventilator dependent resident (R73); failed to closely monitor a resident receiving continuous oxygen and failed to follow physician's order to ensure a resident was receiving the correct oxygen flow rate for one resident (R118); and failed to date/label and maintain proper storage of oxygen nasal cannula tubing in a plastic bag when not in use for two (R91, R419) out of four residents reviewed for respiratory care in a final sample of 32. Findings Include: 1. R118's electronic health records documented R118 was admitted in the facility on 3/7/23, with diagnoses not limited to Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia, Dementia, and Depression. R118's Minimum Data Set, dated dated [DATE], shows R118 is moderately impaired with cognition, and is dependent on staff's assistance on dressing, grooming, and personal hygiene. R118's order summary report shows an order for: Oxygen at 2 LPM per Nasal Cannula continuously - Monitor oxygen saturation every shift for Hypoxia (ordered 9/23/24). On 5/13/25 at 11:53 AM, R118 was observed sleeping in bed. R118's oxygen (O2) concentrator was running continuously with the O2 flow rate set to 3 liters per minute (LPM). R118's oxygen nasal cannula tubing was noted on the floor and not inside R118's nose. On 5/13/25 at 11:59 AM, V15 (Agency Licensed Practical Nurse/LPN) verified R118's oxygen order in the electronic health record; R118 should be getting 2 LPM of continuous oxygen via nasal cannula. On 5/15/25 at 9:14 AM, V2 (Interim Director of Nursing) and stated nurses should be monitoring that the resident's oxygen is on the right setting. V2 stated O2 setting is based on the physician's order, and should be followed for effective use. The facility's OXYGEN DELIVERY SYSTEM policy (no date) documents: It is the policy of this facility that oxygen will be delivered to the residents based upon physician's orders utilizing the following systems: A. Oxygen concentrators providing more than 93% oxygen concentration at flow rates ranging from 1 LPM to 10 LPM. 2. R73's clinical records included diagnoses of chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, dependence on respirator [ventilator] status, and encounter for attention to gastrostomy. R73's Minimum Data Set, dated dated [DATE], showed R73 is total dependent on staff assistance for his ADLs (Activities of Daily Living) and is severely impaired with cognition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R73's order summary report showed an order for head of the bed > 45 degrees all the time (ordered 3/10/25). R73's care plan showed R73 has oxygen therapy related to respiratory illness (date initiated 4/25/24) with one intervention that reads, Promote lung expansion and improve air exchange by positioning with proper body alignment (if tolerated, head of bed at 45 degrees). R73's care plan also shows R73 is ventilator dependent related to respiratory failure (date initiated 5/5/21) with on intervention that reads, Keed head of bed elevated above 30 degrees unless providing care or resident request. On 5/13/25 at 12:29 PM, R73's lying in bed awake, non-verbal, tube feeding was running, and his head of bed slightly up to approximately 10 to 20 degrees. R73's face was flushed and noted gasping for air. Surveyor immediately called V17 (Regional Respiratory Therapist/RT). On 5/13/25 12:31 PM, V17 and another RT repositioned R73, suctioned, and raised his head of bed. On 5/13/25 at 12:35 PM, V16 (Agency Licensed Practical Nurse) and V18 (Respiratory Therapy Director) entered R73's room and assessed R73. Vital signs read: 98% oxygen saturation; blood pressure was 130/85; and 102 heart rate. On 5/13/25 at 12:39 PM, V18 (RT Director) stated R73's head of bed should be up at least 30 degrees to avoid aspiration. V18 stated if the head of bed is too low, R73 could aspirate and experience respiratory distress. R73's progress notes, dated 5/13/25 at 1:52 PM documented by V16, reads in part: [V16] was alerted by respiratory that R73 was in distress. R73 was assessed. Vitals were taken and were 130/85, pulse 102, oxygen 98. V42 (Nurse Practitioner) was notified and will come in the facility to assess R73. The facility's VENTILATOR SET UP (no date) documents: It is the policy of this facility that the respiratory therapist will ensure ventilator equipment is in place and that the patient is received and stabilized in an orderly manner. 49486 3. R91's Minimum Data Set (MDS), dated [DATE], Brief Interview Score (15) indicates R91 is cognitively intact. R91's Physician Order Sheet (POS), dated 5/13/25, shows an active diagnosis of chronic respiratory failure with Hypoxia, chronic obstructive pulmonary disease, chronic systolic congestive heart failure, and chronic ischemic heart disease. R91 has an active order for oxygen at 3-4 Liters per minute, per nasal cannula continuously for Shortness of Breath (SOB) and wheezing. On 5/13/25 at 12:35 PM, V3 (Licensed Practical Nurse/LPN) entered R91's room. R91 was up in bed, oxygen nasal cannula tubing hanging on his wheelchair touching the floor, not dated, and not in a plastic bag. V3 stated the oxygen tubing should be dated and in plastic bag when not in use to prevent contamination, and she will discard the tubing right now. 4. R419's Minimum Data Set (MDS), dated [DATE], Brief Interview Score (15) indicates R419 is cognitively intact. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R419's Physician Order Sheet (POS), dated 5/13/25, shows active diagnoses of acute respiratory failure with hypercapnia, dependence on respirator ventilator status, and chronic obstructive pulmonary disease. R419 has an active order for oxygen at 2 liters per minute, per nasal cannula every day and evening shift. On 5/13/25 at 12:54 PM, V5 (Respiratory Therapist) entered R419's room. R419's oxygen nasal cannula tubing hanging on the oxygen concentrator tank, not dated, and not in a plastic bag. V5 stated having the oxygen nasal cannula hanging out on the oxygen tank makes R419 at risk for breathing in germs like bacteria, and the oxygen nasal cannula should have been contained in a plastic bag when not in use. V5 also stated the tubing should be dated weekly so that staff will know when the tubing was changed. On 5/15/25 at 8:56 AM, V2 (Interim Director of Nursing/DON) stated it is his expectation nurses will change, and date oxygen nasal cannula tubing every Thursday night, and as needed. He also stated that oxygen nasal cannula tubing should be stored in a plastic bag when not in use to maintain good hygiene and prevent infection as much as possible.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review, the facility failed to ensure food items were properly labeled and dated. These failures have the potential to affect all 130 residents receiving food prepared in the facility's kitchen. Findings include: On [DATE] at 9:15 AM, V20 (Food Service Director) stated all items in the refrigerator should be labeled and dated with a delivery date, an open date, and use by date. V20 stated highly perishable items are discarded after seven days. V20 stated it is everyone's responsibility to label and date items. V20 stated labeling and dating items in the refrigerators are important so the staff does not serve outdated or expired food to the residents which could potentially make them sick. On [DATE] at 9:18 AM, the following items were found in the walk-in refrigerator: 1.) Sliced ham hand wrapped in plastic wrap, dated [DATE]. V20 stated the date [DATE] was the day the ham was sliced by the staff in the kitchen. The package was not labeled with a use by date. 2.) Large plastic container of grape jelly covered in plastic wrap. There was no label or opened or use by date. 3.) Opened 5-pound bag of shredded mozzarella cheese, dated with delivery date [DATE]. The item was not labeled with an open or use by date. On [DATE] at 9:35 AM, inside the reach in cooler observed the following item: 1.) Opened 5-pound container of sour cream labeled with a delivery date [DATE]. There was no use by or opened date on the container. V20 stated since it is not labeled with an opened date, there is no way of knowing how long it has been opened, and it should be used within one week from the opened date. On [DATE] at 1:32 PM, V25 (Registered Dietitian) stated, Labeling and dating is important to ensure the food is not bad or spoiled, and then potentially be served to a resident. For this reason, it is important for items to be labeled with an opened date and a use by date, so the staff knows when the food items should be tossed out. The potential problem with foods not being labeled or dated is the possibility that someone could get sick from bad food if served beyond the expiration date. On [DATE], facility provided list of diet orders for all residents in the facility. The diet order list indicates there is 26 residents receiving nothing by mouth (NPO). Facility provided policy titled, Food Storage (Dry, Refrigerated and Frozen), dated 2020, documents all food items will be labeled, and the label must include the name of the food and the date by which it should be sold, consumed, or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided policy titled, Cold Storage Areas, undated, documented to date, label, and properly secure all products removed from original containers with all items labeled stating the contents inside, the date opened and the appropriate use-by-date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on observation, interview, and record review, the facility failed to ensure a visitor entering a contact isolation room was wearing proper personal protective equipment (PPE) for one resident (R67), and failed to ensure staff wore the proper PPE when providing care for 3 (R41, R72, R219) residents on Enhanced Barrier Precautions. These failures has the potential to affect 60 residents residing on the third floor, and 60 residents residing on the fourth floor. Findings Include: 1. R219 was admitted to the facility on [DATE], with diagnoses not limited to Type 2 Diabetes Mellitus with Hyperglycemia, Acute Kidney Failure, Dependence on Renal Dialysis, Gastrostomy, Hypertensive Heart Disease, Shaken Infant Syndrome, Cerebral Palsy, Epilepsy, Abnormalities of Gait and Mobility, Polycystic Ovarian Syndrome, and Blindness, Both Eyes. R219's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) indicates resident is rarely/never understood. R219's Order Summary Report documents: Enhanced Barrier Precautions: Dialysis catheter. Every shift. Order date 04/30/25. On 05/13/25 at 12:08 PM, R219 was observed in bed. V8 (Restorative) was observed in R219's room adjusting R219's brief. Enhanced Barrier Precaution signage was observed at R219 room entry. V8 did not have on a gown while providing care. V8 stated, I was adjusting (R219's) diaper. (R219) has a g (gastric) tube. I should have on PPE (Personal Protective Equipment), a gown and gloves. I did not have on a gown. On 05/15/25/ at 09:16 AM, V2 (Interim Director of Nursing) stated, When providing care for a resident on Enhanced Barrier Precautions, the PPE (Personal Protective Equipment) that should be worn is a gown and gloves, as stated on the signage. If the gown and gloves are not worn, there is a potential for the spread of infection. Enhanced Barrier Precautions Signage documents: Stop, Providers and staff must also: Wear gloves and a gown for the following High Contact Resident Care Activities. Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central lie, urinary catheter, feeding tube, tracheostomy. Policy: (continued on next page)

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	05/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Titled Enhanced Barrier Precautions (EBP), revised 04/01/24, documents: Purpose: To minimize the risk of acquiring, transmitting, or complications resulting from multi-drug-resistant organism (MDRO) colonization among residents in this setting. (Contact precautions would be warranted over EBP when there is a risk of transmission of an actively infectious agent). Populations Affected: Residents with existing or colonized MDRO's where other transmission-based precautions are not warranted. Residents at increased risk of MDRO acquisition (Residents with wound or indwelling medical devices). Equipment Needed: Gowns, Gloves, Room Notification signage. Guidelines: Residents will require the use of personal protective equipment (PPE) for high-risk activities such as: bathing, dressing, toileting, transferring residents, linen changes, wound care, handling indwelling medical devices. PPE required: Gowns, Gloves. Persons expected to encounter these circumstances are to don PPE (gown and gloves) in accordance with the activity that will be encountered when caring for the Resident. 44103 2. R67's Order Summary Report, printed on 5/14/25, reads: Contact Isolation Precautions: Clostridium Difficile CDIFF every shift for 10 days (ordered 5/6/25). R67's care plan shows R67 is on contact isolation precautions due to positive test for clostridium difficile, CDIFF with one intervention reads in part: Educate resident/family/staff regarding safety guidelines and infection control procedures. On 5/13/25 at 12:49 PM, R67's room was observed with an isolation cart setup outside her room. A contact precautions signage was noted posted on R67's door that indicates: Everyone must clean their hands, including before entering and when leaving the room. Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. V37 (R67's Family Member) was inside R67's room, not wearing isolation gown or gloves. Surveyor attempted to interview R67 and V37, but both stated they do not understand English. On 5/13/25 at 12:55 PM, V12 (Licensed Practical Nurse) stated R67 is on contact isolation for Clostridium difficile (C. diff). V12 stated R67 is still on current antibiotic treatments. V12 stated she calls R67's family member to communicate with R67. On 5/13/25 at 12:57 PM, V11 (Infection Preventionist/Registered Nurse) stated the nurse and the isolation signage should inform staff and visitors what proper PPE to wear when entering a resident's room on transmission-based precaution. V11 stated the family is educated, and the facility's receptionists should notify visitors if a resident is on isolation precaution. V11 stated V37 should have been notified R67 is on contact isolation, and V37 should be wear proper PPE (gown and gloves) inside R67's room. V11 stated it is important for staff and visitors to wear proper PPE inside a resident's room on transmission-based precaution to eliminate transmission of C. diff or any bacteria the resident has. The facility's Infection Precaution Guidelines, dated 5/15/23, documents: It is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions. In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items. 49486 (continued on next page)

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	05/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R41's Minimum Data Set (MDS), dated [DATE], Brief Interview Score (12) indicates R41 is moderately cognitively intact. R41's Physician Order Sheet (POS), dated 5/14/25, shows an active diagnosis of chronic respiratory failure with Hypoxia, hypertensive heart and chronic kidney disease with stage five end stage renal disease, dependence on renal dialysis, and scabies. R41 has an active order for enhanced barrier precautions. 4. R72's Minimum Data Set (MDS), dated [DATE], Brief Interview Score (10) indicates R72 is moderately cognitively intact. R72 Physician Order Sheet (POS) dated 5/14/25 shows an active diagnosis of encounter for attention to gastrostomy. R72 has an active order for enteral feed every 4 hours gastrostomy tube water flush 150 milliliter (ml). On 5/14/25 at 9:25 AM, observed V22 (Registered Nurse/RN-Agency) entering R72's room flushing her gastrostomy tube (GT) without wearing a gown as Personal Protective Equipment (PPE). At 9:28 AM, V22 also entered R41's room to take her blood pressure reading without wearing a gown. Surveyor asked V22 why she entered R41 and R72's rooms without wearing PPE despite an Enhanced Barrier Precautions (EBP) signage posted by the door? She stated, You cannot interview me because I am from the agency, and she stated she should have worn gown before entering both rooms, but nobody gave her report as to what she needs to do when providing contact care to residents with EBP signage. Surveyor asked V22 what could be the potential effect of what she has done? She did not respond, and moved away from surveyor. On 5/14/25 at 11:43 AM, V34 (Registered Nurse/RN) stated all staff and visitors should read and follow instruction on the EBP signage by the door to ensure correct PPE is/are worn before providing direct care like GT, dialysis arteriovenous (AV) fistula monitoring, wound care, tracheostomy care, taking of blood pressure reading, and Foley catheter care. A gown and a pair of gloves should be worn to prevent cross contamination, and cross transmission of infection. On 5/15/25 at 8:56 AM, V2 (Interim Director of Nursing/DON) stated the agency staff should be following the policy and procedure of the facility regarding patient's care, and there should be a physician order for EBP. It is V2's expectation that nurses, either agency or regular staff, will read, follow signage, wear a gown and gloves when providing contact care like; GT, wound, urinary catheter, dialysis (AV) fistula, and taking of blood pressure reading especially for a resident with diagnosis of scabies with a (AV) fistula. V2 also stated V22 should wear a gown when providing any contact care to R41, R72, and any residents with EBP signage by the door to prevent spread of infection. The facility EBP signage posted by the doors of R41 and R72's rooms documents: Wear gloves and a gown for high contact resident care activities.