

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/02/2025
NAME OF PROVIDER OR SUPPLIER  Elevate Care North Branch		STREET ADDRESS, CITY, STATE, ZIP CODE  6840 West Touhy Avenue Niles, IL 60714	

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 - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41758</p> <p>Based on observation, interview and record review, the facility failed to follow their incontinence care policy by not checking for incontinence at least every two hours. This affected one of three residents (R1) reviewed for incontinence care. This failure resulted in R1 being soaked in urine for and not checked for incontinence for at least 4 hours.</p> <p>Findings Include:</p> <p>R1's minimal data set section C (cognitive pattern) dated 2/21/25 documents a score of fourteen which indicated cognitively intact. Section GG (functional abilities) document: toilet hygiene dependent helper does all the work. Resident does none of the effort to complete the activity. Section H documents: urinary continence: always incontinent.</p> <p>On 3/1/25 at 11:23am, V4 (CNA) said she started her shift at 7am. V4 said she checked on R1 between 7:00am -8:30am. R1 did not ask to be changed at that time. V4 said R1 asked for some water and a blanket which V4 provided. V4 said this is the first time she was providing incontinence care to R1. R1 had a strong smell of urine. R1 was observed with a saturated adult brief, a reddened area on the left inner thigh consistent with R1's sack and penis print, sheet prints on anterior/posterior thighs, wet bed sheet and mattress. V4 and V5 (nurse) both said, R1 had a strong smell of urine. R1's adult brief was saturated with urine. R1's bedsheet and mattress were wet with urine. V5 said the prints on R1's skin are from laying on the bed sheets. V5 said this amount of urine did not occur in two hours. V5 said R1 is a heavy wetter.</p> <p>On 3/1/25 at 11:42am, R1 who was assessed to be alert, orient to person, place and time, said he screamed all night to be changed. R1 said he was changed around 1or 2 am and at 7:15am by the night shift CNA. R1 said, he urinated again and asked to be changed which the night CNA refused and said, I just changed you. R1 was unable to recall the night CNA's name. R1 said he was able to tell what time it was because there is a clock on the wall. R1 had a clock on the wall displaying the correct time that could be seen from R1's head of bed. R1 said, I need to be changed every hour, but staff will tell me I have to wait until every two hours.</p> <p>On 3/1/25 at 2:35pm, R4 (R1's roommate) who was assessed to be alert, orient to person, place and time, said R1 screamed for help all night long.</p> <p>On 3/1/25 at 2:53pm, V6 (DON) said residents should be changed every two hours and as needed to include their request.</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 - Few</p>	<p>Incontinence Care Policy dated 11-28-12 documents: 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>