STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care North Branch	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one (R2) of three residents reviewed for abuse was protected when the facility did not adequately identify, intervene, and protect residents from resident-to-resident abuse. This failure resulted in a resident being exposed to the potential for harm. During the investigation observations were made, interviews were conducted, and records were reviewed. R2 will be known as R2 and is the subject of this Complaint InvestigationR1 will be known as R1 and is the alleged perpetrator. R2 is a [AGE] year-old female who was originally admitted to the facility on [DATE] and continues to reside in the facility. R2 has multiple diagnoses including but not limited to the following: dementia in other diseases classified elsewhere, mild, with agitation, anxiety disorder, unspecified. R2's transfer status is 1- person assist. R2 can ambulate with the assistance of a wheelchair and self-propels. R2's comprehensive assessment section C cognitive status dated 11/10/2025 documents a brief interview for mental status score of 4 out of 15. A score from 0 to 7 indicates the person is considered to have severe cognitive impairment.R2's psychiatric note dated 11/27/25 states R2 is a [AGE] year-old female with a psychiatric history of dementia with hallucinations, anxiety and depression seen for f/u psychiatric evaluation. She was evaluated in her room, seated in her wheelchair, awake, verbal, and cooperative, though communication remained limited by her baseline confusion and preference for Bulgarian. She appeared intermittently anxious and restless but remained able to participate in simple conversation. She continues to show progressive cognitive decline marked by worsening irritability, decreased tolerance for environmental stimulation, and difficulty redirecting during care. No overt hallucinations or delusional thinking were observed, and staff deny clear psychotic behaviors at this time. Despite a recent increase in her evening dose of quetiapine, she continues to have occasional episodes of yelling out and behavioral dis-inhibition, most often triggered by interactions with her roommate or when someone enters her personal space. These episodes remain brief and generally respond to redirection. Sleep and appetite have remained stable, and there have been no recent medical complications reported. R2 social service notes dated 11/4/25 states Well-being check done, R2 is in good spirits, no behavioral symptoms exhibited at this time. No emotional distress exhibited. R2 nursing note dated 11/3/25 states NP updated regarding increase anxiety and agitation, keeps going to other resident's room. Fighting with staff and this writer whenever trying to stop her. Behavior difficult to redirect. NP increased R2's Seroquel and sertraline, orders noted and confirmed. NP gave order for CBC/CMP in am, UA/CS, noted and carried out. R2 nursing notes dated 11/2/25 states R2 is stable during shift, no complaints of pain or discomfort. No changes of LOC. Vital signs are stable. R2 still observe wandering and tend to go to other rooms despite multiple redirections provided. Endorsed accordingly. R2 progress note dated 11/1/25 - Head to toe assessment done- Noted with small open skin on left eyelid, no bleeding, swelling or bruising noted at this time. neuro check initiated, no changes in (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LOC- R2 is calm, not on any form of distress noted. endorsed accordingly. R1 progress note dated 11/1/25 states Head to toe assessment done, neuro check initiated, wellbeing check and resident is calm. R1 progress note dated 11/1/25 states R1 has had a behavioral episode. Please see the Behavior Observation for details. During the investigation dated 1/7/2026 to 1/8/2026, the surveyor observed the staff providing nursing care to residents while touring the unit. During observations and interviews the surveyor had no identified issues or concerns regarding resident to resident physical abuse, quality of patient care/treatment, improper nursing care, and resident/patient/client rights. Surveyor reviewed grievance/complaint binder for last six months for physical/mental/verbal abuse, quality of care/treatment, patient care, improper nursing care. No issues or concerns were identified.R1 and R2 were reviewed for resident to resident physical abuse with no concerns noted. On 1/7/2026 at 8:45AM surveyor observed nurses performing medication administration, call lights being answered within seconds to minutes. Surveyors noted residents being cleaned up after meals. Surveyor did not notice any resident to resident verbal/mental/physical abuse, neglect or not receiving quality of care/treatment. Surveyor noticed residents up and out of bed. Surveyor did not notice any resident linens to be dirty or soiled, foul odors. Surveyor noticed majority of residents up for meals.On 01/07/2026 at 12:55 surveyor observed R2 in her bed confused, and anxious. R2 was sitting in bed restless and not able to focus. R2 was dressed appropriately for the weather and was wearing shoes. R2 bed was in the lowest position, call light and wheelchair were next to the bed. Surveyor observed R2's face and head with no signs of injuries, bruising, swelling, discoloration. R2 is non-Interviewable due to severe cognition impairment.On 01/07/2026 at 1:10PM surveyor observed R1 in her room sitting in a wheelchair. R1 was watching TV and in good spirits. R1 was confused and forgetful. R1 couldn't remember when or who but said a lady came into her room and she told her to get out but she wouldn't leave. R1 said that's when she started yelling and trying to push the lady out of the room. R1 said she felt guilty and bad about hitting her in the face, but she was just trying to get her out of the room. R1 said it hurts her knowing that she had hit the lady but wanted her out, but she wouldn't listen. R1 said she feels safe and hasn't had any problems with any other residents since then.On 01/07/2026 at 1:30PM V5 (Nurse Supervisor/RN) said V9 (Licensed Practical Nurse/LPN) called her to R1's rooms because they had an argument and R2 had been hit in the face by R1. V5 (Nurse Supervisor/RN) said R2 is AxOx1, has dementia and is confused. V5 (Nurse Supervisor/RN) said R2 had wondered into R1's room and when R1 was yelling for her to get out, R1 had hit R2 in the left eye because R2 wouldn't leave. V5 (Nurse Supervisor/RN) said she did a head-to-toe assessment on R2, and she had some redness under the left eye but no bleeding, bruising or report of pain. V5 (Nurse Supervisor/RN) said R2 didn't need to be sent out to the hospital, but the doctor, administrator, director of nursing, and family were all notified per facility policy. V5 (Nurse Supervisor/RN) said R2 was observed for 3 days, and wellness checks were performed. V5 (Nurse Supervisor/RN) said there have been no other incidents between R1 and R2On 01/07/2026 at 1:40PM V4 (Licensed Practical Nurse/LPN) said she was the nurse's station when she heard a loud noise and voices in R1's room. V4 (LPN) said by the time she got there V9 (Licensed Practical Nurse/LPN) had already separate R1 and R2. V4 (Licensed Practical Nurse/LPN) said she did a full body assessment of R1, and she had no injuries, bruising, scratches or reports of pain. V4 (Licensed Practical Nurse/LPN) said R1 was going to leave the room when R2 was entering and R1 tried to stop R2 but she didn't listen or understand since R2's is confused and English isn't her first language. V4 (Licensed Practical Nurse/LPN) said she did notice a small scratch under R2's eye but no bleeding, bruising, or swelling. V4 (Licensed Practical Nurse/LPN) said there haven't been any altercations before or after this one incident. On 01/07/2026 at 2:00PM V2 (Assistant (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Services Director) said she interviewed both R1 and R2 after the incident took place. V2 (Assistant Social Services Director) said R2 got lost and confused and attempted to enter R1's room. V2 (Assistant Social Services Director) said that's when staff heard a commotion, and they tried to intervene but they found both R1 and R2 in a disagreement and the altercation of R1 hitting R2 in the face had already taken place. V2 (Assistant Social Services Director) said there hasn't been any other altercations between R1 and R2. V2 (Assistant Social Services Director) said during her interview both R1 and R2 expressed they feel safe. R2 progress note dated 1/7/26 states Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation for 14 Days. PRN Administration was: Effective Review of the facility policy titled Abuse Prevention and Reporting- Illinois requires the facility to protect residents from all forms of abuse, including resident-to-resident abuse. The facility failed to follow its policy. Definitions: Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines).