STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145662	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Niles	8333 West Golf Road 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 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish a correct indication and frequency in the use of antipsychotic medication (Seroquel); failed to obtain complete consent for use of antipsychotic medication; and failed to adequately monitor adverse reactions, evaluate effectiveness and relevance of antipsychotic medication on a resident with Alzheimer's disease. This failure resulted in R1 hanging himself with a cellphone cord and required emergent transfer to the hospital.Findings include:R1 is a [AGE] year-old, male, admitted in the facility on 02/14/26 with the following diagnoses: Alzheimer's Disease, Unspecified; Unspecified Dementia, Moderate, with other Behavioral Disturbance; Memory Deficit Following Cerebral Infarction and Restlessness and Agitation.R1's MDS (Minimum Data Set) dated 02/21/216 documented:Sec C: BIMS (Brief Interview for Mental Status) score of 5, which means severe cognitive impairment.Sec D:A. Little interest or pleasure in doing things, 7-11 days (half or more of the days)B. Feeling down, depressed, or hopeless, yes, 7-11 days (half or more of the days)C. Trouble falling or staying asleep, or sleeping too much, yes, 2-6 days (several days)D. Feeling tired or having little energy, yes, 2-6 days (several days)F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down, yes, 2-6 days (several days)G. Trouble concentrating on things, such as reading the newspaper or watching television, yes, 7-11 days (half or more of the days)Physician visit Summary dated 01/09/26 documented that R1 was prescribed to take Quetiapine (Seroquel) 50 mg (milligrams) tablet by mouth nightly as needed (sleep) for up to 60 days. R1 was assessed to have Insomnia, unspecified type. V23 (Physician) also attached a doctor's note that R1 needs nursing home or facility for 24-hour care and did not exhibit aggressive behavior or show signs of aggression.Progress notes dated 02/14/26 documented R1 was admitted in the facility.On 04/15/26 at 9:45 AM V3 (Assistant Director of Nursing) was asked regarding medication orders upon admission. V3 stated, He takes Seroquel, Hydroxyzine, Memantine and Melatonin upon admission. V3 showed surveyor the Quetiapine bottle that R1 presented during admission. The prescription reads: Quetiapine Fumarate 50mg 1 tablet as needed for insomnia at bedtime.In R1's POS (Physician Order Sheet) dated 02/14/26, it was entered as Quetiapine Fumarate oral tablet 50 mg give 1 tablet by mouth at bedtime for dementia.R1's consent for Quetiapine (Seroquel) dated 02/14/26 did not indicate date the consent was given and there was no name of authorized person giving consent.Progress notes dated 02/17/26 authored by V20 (Attending Physician) and psychiatry progress notes dated 02/20/26 written by V19 (Nurse Practitioner, Psychiatry) recorded: Quetiapine 50mg every hours of sleep (bedtime). V19 indicated Quetiapine for dementia related agitation.On 04/14/26 at 12:03 PM, V19 (Nurse Practitioner, Psychiatry) was interviewed regarding R1. V19 stated, He does have a diagnosis of Alzheimer's disease, high-functioning, ambulatory, able to feed self. Able to engage, very pleasant guy. He had some underlying anxiety-dementia related. He had a diagnosis of neurocognitive disorder related to Alzheimer's, Dementia. Initially he came from home. He was on Memantine, on Seroquel 50 mg at night and he had PRN (when needed) Hydroxyzine and was discharged from hospital with these medications. I had the initial evaluation on 02/20/26 and at the time he was only taking Seroquel and Hydroxyzine PRN, as well as Melatonin. I just continued the medications. I did another evaluation a (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 0757 Level of Harm - Actual harm Residents Affected - Few	few weeks after and he was having increased anxiety per staff, Buspirone was added. Seroquel was prescribed, I believe during hospitalization, it was prescribed because of a sundowning episode and dementia related.On 04/14/26 at 1:27 PM, V20 (Attending Physician) was also asked regarding R1. V20 replied, He had dementia, he had cognitive impairment. I didn't do any memory assessments formally. He was on Memantine. I didn't see any unusual behavior when I saw him. There were no reports, not that I noticed too when I was visiting. Seroquel is for mood control, not for dementia but for agitation. He'd been taking it before admission, we continued it.R1's Physician visit summary dated 03/07/26 documented: Quetiapine (Seroquel) 50 mg tablet take 1 tablet by mouth nightly as needed (sleep) for up to 60 days. Indication: Insomnia, unspecified type.There was no clarity regarding indication and frequency related to R1's order for Quetiapine (Seroquel).On 04/13/26 at 2:03 PM, V15 (Licensed Practical Nurse, LPN) was asked regarding R1. V15 stated he was confused all the time and wandered from room to room. V15 added, He just walked around the unit. Polite, kind, quiet and loved to walk around. R1 was confused, alert, oriented to self. He was able to walk, pour himself water, and do most of his daily activities independently.On 04/13/26 at 2:46 PM, V13 Certified Nurse Aide, CNA) also verbalized, R1 was friendly. I saw him walking around the hallway. He does everything by himself.On 04/13/26 at 4:20 PM, V18 (LPN) mentioned, R1 was very confused. I checked on him when I would go into his room, when I saw him wandering, I redirected him. Normally, he wanders along the hallway, asking where his room was, redirection is provided.R1's progress notes dated 03/11/26 documented that he was reported going into another resident's room a few times during the night. Progress notes dated 03/11/26, time stamped 9:16 PM also documented he was observed wandering hallway throughout shift entering other residents' rooms. Progress notes dated 03/31/26 also stated his roommate complained about his (R1) wandering around the room during night.Psychiatry progress notes dated 03/12/26 stated that R1's sleep was poor with nighttime wandering and entering other resident's rooms, Buspirone was increased to 7.5 mg BID (twice a day) to address ongoing anxiety; and to continue Quetiapine 50mg at bedtime.Per POS, R1's Buspirone was initially ordered on 03/05/26 at 5 mg twice a day for anxiety.A review of R1's care plans revealed the following:Potential for cognitive problem related to Alzheimer's Dementia, Forgetfulness, Confusion, Poor historian, initiated 02/25/26: Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness.There was no care plan specifically addressing R1's use of antipsychotic medication; ongoing monitoring for adverse effects, and/ or changes in behavior. There was no documentation of ongoing assessment or behavior flowsheets regarding response to antipsychotic medication and its effectiveness. R1's physician progress notes dated 02/17/26 documented:Past medical history: Alzheimer's dementia, moderate to severePlan: continue Quetiapine 50mg QHS (at bedtime); monitor for sedation, EPS (extrapyramidal symptoms), metabolic effects.During interview with V19 on 04/14/26 at 12:03 PM, he mentioned sedation is most common side effect of Seroquel. V19 continued, Seroquel side effects are metabolic, sedation is most common. There is an increased sedation risk, staff has to monitor for safety and behavior. Increased agitation, increased psychosis, delusion, safety and needs close monitoring, frequent rounding while taking this medication. They have to notify me if behavior is worsening. Anything acute could be considered medical condition, labs like urinalysis is needed.V20 verbalized during interview on 04/14/26 at 1:27 PM that for elderly demented people, sedatives are not recommended. V20 continued, We should avoid sedatives, a patient already has cognitive impairment, and it can knock him out for 1-2 hours but it has a longer effect in the brain and can make patients more confused, more agitation and increasing anxiety.On 04/15/26 at 2:08 PM, V22 (Psychiatrist) was asked regarding use of antipsychotic medication such as Seroquel. V22 replied, Seroquel is an antipsychotic medication, for schizophrenia, psychotic spectrum disorder, bipolar disorder. Off label for agitation related dementia, meaning not FDA (food and drug administration) approved, significant data behind this as an effective treatment. If a resident has no agitation, it is the job of clinician if medications could be continued or not. They have to do psychiatric assessments which includes dementia related (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	behavior, anxiety or any psychiatric conditions. Seroquel is sedative.Progress notes dated 04/03/26 documented R1 was found hanging with cellphone cord around his neck, unresponsive still with pulse, skin was noted cyanotic. He was brought down to bed, was assessed and provided with oxygen, paramedics were called, transferred to hospital.Hospital records dated 04/03/26 documented R1 presented with traumatic cardiac arrest, last seen around 10:30 AM, at 11:45 AM was found hung himself with a cable around his neck and cardiac arrest. Ligature marks around the neck, no other traumatic injuries. R1 was intubated in the field.Death Certificate dated 04/13/26 recorded R1 passed away on 04/08/26 due to complications of hanging.On 04/15/26 at 1:37 PM, V2 (Director of Nursing) was asked regarding use of psychoactive medications. V2 verbalized, Care plan should be initiated for psychotropic medications. We need to monitor side effects such as increased confusion, EPS (extrapyramidal symptoms), poor appetite. Nurses monitor for side effects after giving medication, nurses and CNAs (Certified Nurse Aides) monitor for any side effects. They are to report to me if they see any unusual behavior and whole clinical aspect of the resident; proper communication with physician and family if any changes are noted.Facility's policy titled Psychotropic Medication - Gradual Dosage Reduction dated 2-1-18 documented in part but not limited to the following:Purpose:To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice, and are prescribed at the lowest therapeutic dose to treat such conditions.Guidelines:Informed consent shall be obtained as follows:Psychotropic medication shall not be administered without the informed consent of the resident or the authorized resident representative.The plan to alternatives to psychotropic medication and/ or use of psychotropic shall be incorporated into the care plan with suitable goals and approaches. This will be initiated by the resident's needs/problems, goals and approaches as it relates to the use of psychotropic drug use.Monitoring:Staff will monitor residents for side effects, withdrawal symptoms and/ or changes in behavior and report to physician and/ or psychiatrist. Documentation of observed side effects by nursing staff will occur as indicated in the nurses notes and/ or on the EMAR.Facility was requested to present any behavior management policy but nothing was submitted.