

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2025
NAME OF PROVIDER OR SUPPLIER Elevate Care Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Audrey Nixon Boulevard Waukegan, IL 60085	

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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to protect a resident (R1) from physical abuse by a visitor, and failed to protect a resident (R2) from verbal abuse by a visitor. These failures apply to 2 of 3 residents reviewed for abuse in the sample of 4. The findings include:1.R1's electronic face sheet, printed on 7/19/25, showed R1 has diagnoses including but not limited to severe protein-calorie malnutrition, dysphagia, thrombocytopenia, and dementia without behaviors.R1's facility assessment, dated 7/3/25, showed R1 has severe cognitive impairment and does not exhibit behaviors.R1's care plan, dated 7/3/25, showed, (R1) displays socially inappropriate and maladaptive behavior as manifested by: Attempting to manipulate fecal matter; to draw attention to oneself or a manipulation for special privileges. These symptoms are related to anger/agitated depression, communicating anxiety and restlessness, and trying to spit on staff.The facility's document titled, Preliminary 24-hour Incident Investigation Report, dated 7/17/25, showed, On 7/17/25 it was reported to (V1, Administrator) that the family member of (R1) made physical contact with her.On 7/18/25 at 5:47PM, V1 (Administrator) and V2 (Director of Nursing) were interviewed regarding the incident with R1 and her daughter. V2 stated V4 (Registered Nurse) notified him she heard a slap between (R1) and her daughter. She didn't see the altercation, but she heard it, and then (R1) was crying. On the camera, I saw the daughter pushing her mom around the 4th floor hallway from her room to family dining room, she went to window and showed her outside window, went out to the hallway to the other side, and they were walking towards the bird cage, but before they arrived, the daughter slapped her, and yanked the wheelchair around so (R1) was facing the wall. She grabbed a tissue, wiped (R1's) face forcefully and then she continued pushing her towards the bird cage. We notified police, and an officer came right out, and he took statements from all the staff. We showed the officer the video and uploaded it to the police portal. Right now (V7) is unable to visit (R1) until we have concluded or investigation. This is a case of physical abuse and that's how we are going to handle it moving forward with Adult Protective Services.The facility's interview with V7 (R1's daughter), dated 7/18/25, showed, (V7) stated, Every day I walk my mom around the halls. I told my mom not to spit, mom said 'f*ck you' and spit, so all I did was tap her face and tell her no.This surveyor observed the facility's camera footage from 7/17/25. V1 and V2 were in the room with surveyor when viewing camera footage. The footage shows a woman (identified as V7 by V2) wheeling R1 down the hallway, bringing her arm back above her shoulder and bringing it down while slapping R1 on the left side of the face. R1 immediately grabs the left side of her face and begins crying. V7 then swings R1's wheelchair around forcefully, grabs a tissue out of R1's hand, and forcefully wipes R1's face while R1 holds the left side of her face. V7 then continues to push R1 down the hallway, as if nothing occurred.Surveyor attempted to interview R1 regarding the 7/17/25 incident with translation assistance from V3 (Nursing Supervisor); however, R1 has severe cognitive impairment and could not recall the incident.On 7/19/25 at 12:25PM, V4 (Licensed Practical Nurse) stated, I was (R1's) assigned nurse that night, I was at the nurse's station charting and (V7 and R1) were walking around and were towards the service elevator and then I heard a smack and a cry. I immediately got up and saw they were there and escorted them to (R1's) room and told (V7) to leave the facility immediately. I told her we needed to assess her mom and she did agree to leave and left the facility. I assessed (R1) for injuries, and she had some redness on her left cheek otherwise nothing else. (R1) is very confused, she didn't seem like anything had happened and already didn't remember what happened. (V7) is here all the time and brings (R1) food and is normally very caring. She came in the same as she always does and happy and not angry. I am completely shocked by this behavior from (V7).On 7/19/25 at 2:22PM, V6 (Certified Nursing Assistant) stated, We could hear a noise that sounded like a slap, but it was weird to hear. I looked down the hallway and (R1) was holding her face and her daughter (V7) was turning her chair around really fast and (V7's) face was red and she looked angry. She proceeded to push (R1) towards the nurse's station and the nurse intervened.The facility's policy titled, Abuse Prevention and Reporting-Illinois, reviewed on 12/17/21, showed, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. this will be done by establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment.abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm pain or mental anguish to a resident Physical</p>		