STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2389122/IL166199 Facility Reported Incident of October 17, 2023 IL165994	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.686 f)1) 300.686 f)2) 300.686 f)3)A) 300.686 f)3)B) 300.686 f)3)C) 300.686 f)3)D) 300.386 f)3)E) 300.686 f)3)F) 300.686 f)3)G) 300.686 f)3)H) 300.686 f)3)I) 300.686 f)5) 300.686 f)6) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications f) Protocol for Securing Informed Consent for Psychotropic Medication 1) Except in the case of an emergency as described in subsection (e), no resident shall be administered psychotropic medication prior to a discussion between the resident or the resident's surrogate decision maker, or both, and the resident's physician or a physician the resident was referred to, a registered pharmacist who is not a dispensing pharmacist for the facility where the resident lives, or a licensed nurse	S9999	**Attachment A** Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

about the most common possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. (Section 2-106.1(b) of the Act)

2) Prior to initiating any detailed discussion designed to secure informed consent, a licensed health care professional shall inform the resident or the resident's surrogate decision maker that the resident's physician has prescribed a psychotropic medication for the resident, and that informed consent is required from the resident or the resident's surrogate decision maker before the resident may be given the medication.

3) The discussion shall include information about:

A) The name of the medication;

B) The condition or symptoms that the medication is intended to treat, and how the medication is expected to treat those symptoms;

C) How the medication is intended to affect those symptoms;

D) Other common effects or side effects of the medication, and any reasons (e.g., age, health status, other medications) that the resident is more or less likely to experience side effects;

E) Dosage information, including how much medication would be administered, how often, and the method of administration (e.g., orally or by injection; with, before, or after food);

F) Any tests and related procedures that are required for the safe and effective administration of the medication;

G) Any food or activities the resident should avoid while taking the medication;

H) Any possible alternatives to taking the medication that could accomplish the same purpose; and

I) Any possible consequences to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

resident of not taking the medication.

5) In addition to the oral discussion, the resident or his or her surrogate decision maker shall be given the information in subsection (f)(3) in writing. The information shall be in plain language, understandable to the resident or his or her surrogate decision maker. If the written information is in a language not understood by the resident or his or her surrogate decision maker, the facility, in compliance with the Language Assistance Services Act and the Language Assistance Services Code, shall provide, at no cost to the resident or the resident's surrogate decision maker, an interpreter capable of communicating with the resident or his or her surrogate decision maker and the authorized prescribing professional conducting the discussion. The authorized prescribing professional shall guide the resident through the written information. The written information shall include a place for the resident or his or her surrogate decision maker to give, or to refuse to give, informed consent. The written information shall be placed in the resident's record. Informed consent is not secured until the resident or surrogate decision maker has given written informed consent. If the resident has dementia and the facility is unable to contact the resident's surrogate decision maker, the facility shall not administer psychotropic medication to the resident except in an emergency as provided by subsection (e).

6) Informed consent shall be sought first from a resident, then from a surrogate decision maker, in the following order or priority:

These requirements have not been met as evidenced by:

Based on interview and record review, the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

failed to obtain informed consent for the administration of psychotropic medications for one of three residents (R3) reviewed for psychotropic medications.

Findings include:

R3's face sheet documents R3 was a 75 five year old admitted to the facility on 9/13/2023 with diagnoses including but not limited to: Acute and Chronic Respiratory Failure With Hypoxia, Acute and Chronic Respiratory Failure With Hypercapnia, Chronic Obstructive Pulmonary Disease, Respiratory Bronchiolitis Interstitial Lung Disease, Encounter For Attention to Tracheostomy, Dependence on Respirator (Ventilator) Status, Lack of Coordination, Atonia, Venous Insufficiency, Acute Kidney Failure, and Hypertensive Heart Disease With Heart Failure.

On 11/14/2023 at 10:42 AM, V20 (LPN-Licensed Practical Nurse) said, "Psychotropic medications cannot be given if consent is not obtained."

On 11/14/2023 at 2:51 PM, V1 (Administrator) said she was unable to find consents for R3's Olanzapine and Trazodone.

R3's Order Summary Report documents the following medication orders:
-Olanzapine Oral Tablet 2.5 MG Give 1 tablet via G-Tube every 24 hours as needed for agitation Order/Start date 9.14.2023
-Trazodone HCL Oral Tablet 50 MG Give 1 tablet via G-Tube one time a day for depression Order/Start date 9.13.2023

R3's EMARs (Electronic Medication Administration Records) for 9/1/2023-9/30/2023, 10/1/2023-10/31/2023 document R3 received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 Trazodone on the following days: 9/13/2023, 9/14/2023, 9/15/2023, 9/16/2023, 9/17/2023, 9/18/2023, 9/19/2023, 9/20/2023, 9/21/2023, 9/22/2023, 9/23/2023, 9/24/2023, 9/25/2023, 9/26/2023, 9/27/2023, 9/28/2023, 9/29/2023, 10/1/2023, 10/3/2023, and 10/4/2023. R3's EMARs document R3 did not receive Olanzapine 9/14/2023-10/4/2023. No informed consent forms for the above medications (Olanzapine, Trazodone) were found in R3's medical record. Facility's "Psychotropic Medication-Gradual Dosage Reduction" policy (Revisions 2.1.18) states, "Informed consent shall be obtained as follows: a) Psychotropic medication shall not be administered without the informed consent of the resident or the authorized resident representative." (C) 2 of 2 300.610 a) 300.1210 b) 300.3240 a) 300.3240 b) 300.3240 d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements are not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

Based on interview and record, the facility failed to ensure that residents are free from staff to resident verbal and mental abuse and failed to thoroughly investigate allegations of abuse for two of two residents (R1,R2) reviewed for abuse. These failures resulted in R1 verbalizing feelings of anger and R2 demonstrating sadness.

Findings include:

R2's medical record (Face Sheet, MDS-Minimum Data Set) documents R2 is a severely cognitively impaired 52-year-old admitted to the facility with diagnoses including but not limited to: Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Atherosclerotic Heart Disease, and Asphasia.

R1's medical record (Face Sheet, MDS-Minimum Data Set is a cognitively intact 63-year-old admitted to the facility with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Chronic Kidney Disease, Stage 4; Major Depressive Disorder, Legal Blindness, and Anxiety Disorder.

Facility's final incident report date 10/24/2023, documents, "On 10/17/2023 at approximately 3:30 PM, it was reported to the administrator that a CNA was rude to these residents (R1, R2) during care. (V4-Former Certified Nursing Assistant) alleged perpetrator declined comment. (R2) said (V4) told me to shut up. (R1) said when (V4) was providing care to me, she was not nice. Social Service Designee (V12-Director of Social Service) said (R2) and (R1) reported to me that the CNA was being discourteous and rude to them when she was providing them care. I reported it to the administrator. I did not witness the event. Based on the investigation, the CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

was suspended from the facility and then terminated from employment for discourteous behavior to residents."
No other residents or staff interviews were documented in the incident report.

V4's (Former CNA-Certified Nursing Assistant) Employee Disciplinary Action Report, dated 10/18/2023 documents: "10/17/2023 Policy Violation, Quality of Work, and Resident Health/Safety Concern. Employee was suspended pending investigation for improper customer service and rude behavior towards two residents on 10/17/2023. Employee was informed via telephone on 10/18/2023 that the allegation was substantiated and she was being terminated for failure to provide customer service to residents and policy violation for dignity and respect."

On 11/7/2023 at 11:11 AM, 12:03 PM, and 2:16 PM, V3 (LPN-Licensed Practical Nurse) said, "I was doing the morning medication pass, it was on a weekend, I don't remember the exact date. I heard (V4, CNA-Certified Nursing Assistant) scream at (R2). She screamed at (R2) to "shut up, you're too loud"." V3 said R2 is non-verbal but makes grunting sounds. V3 said after V4 screamed at R2, R2 appeared upset; R2 put his head down and wheeled himself to his room. V3 said R1 told V3 that V4 was rude to R1 when R1 asked V4 to change R1 sometime in the afternoon on the same day. V3 said she did not report the incident right away; she said waited until Monday when she reported it to the V10 (ADON-Assistant Director of Nursing). V3 said that V4, as far as she knows, continued to work her shift. V3 did not send V4 home. V3 said she did not say anything to V4 when V4 screamed at R2. V3 described V4 as aggressive/abrasive. "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

didn't want to confront her; I knew I was supposed to. I kept checking on (R2) to make sure he was okay."

On 11/7/2023 at 11:20 AM, R1 was observed sitting up in bed. R1 said she asked V4 to change her; "(V4) responded she wasn't going to change me. I told her I was going to report her. She said, 'go ahead, they won't do anything.' It made me really angry."

On 11/7/2023 at 11:57 AM, V5 (CNA-Certified Nursing Assistant) said he would immediately report to the Administrator any abuse.

On 11/7/2023 at 12:08 PM, V6 (CNA-Certified Nursing Assistant) said residents did complain to her that V4 (Former Certified Nursing Assistant) was mean to them. "I didn't report it to anyone. I should report any abuse to the Administrator right away."

On 11/7/2023 at 2:50 PM, V9 (Director of Human Resources) said V4 (Former CNA-Certified Nursing Assistant) was terminated by V1 (Administrator) on 10.18.2023 for improper customer service and dignity and respect.

On 11/7/2023 at 3:07 PM, V1 (Administrator) said, "(V3,LPN) reported the allegation to Social Service Designee (V12, Director of Social Service), during stand-up meeting at approximately 9:45 on 10/17/2023. Social Service Designee then reported to me on the phone on 10/17/2023. I wasn't in the facility at the time. I pulled over, did the reportable on my phone."

On 11/7/2023 at 3:35 PM, V10 (Assistant Director of Nursing/ADON), stated, "I was made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

it I believe it was on Monday morning; I was informed during stand-up. (V3, LPN) said (V4, Former CNA) yelled at (R2) to shut up. I don't when this happened off the top of my head, I feel like it was three weeks ago. (V9, Director of Human Resources) would have that information because we suspended her (V4) pending investigation." V10 confirmed both V3 and V4 were working at the same time. "It happened a couple days prior to me hearing about it; that (V4) yelled at (R2) and was rude to (R1)."

On 11/7/2023 at 2:41 PM, V12 (Director of Social Service) said. "I found out during morning rounds on the 4th floor, I don't recall the date or time. (V3, LPN) stated this during morning rounds. (V3) said she witnessed (V4, Former CNA) yelling at (R2); (V4) told him to shut up and go to his room. The resident (R2) was down, not himself, he was quiet, isolating himself in his room after the incident. He's (R2) on the unit on the daily. I followed up with (R1). She said that (V4) came into the room, (R1) asked for another CNA, (V4) brushed her off, was extremely rude, using profanity, and told (R1) she was stuck with her (V4)." V12 said, "It's not appropriate behavior; its verbal abuse and should be reported immediately."

On 11/7/2023 at 4:45 PM, V12 (Social Service Director) said, "It happened on 10/17." Surveyor replied, "no it was reported on 10/17." V12 said V4 didn't work on 10/14 or 10/15. V12 said, "I don't when it happened if you're telling me it was reported on 10/17."

On 11/7/2023 at 4:56 PM, V10 (Assistant Director of Nursing/ADON) said, "(V1, Administrator) said to me, we have to clarify when (V3) would have heard (V4) say this. I don't know if it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

assumed that I was doing it (interviewing V3). (V2) was the DON at the time of the incident, I don't know if she asked her (V3) what happened. I did follow up with (V3); I asked when she would have witnessed this, when (V4) was working PMs and you (V3) were working days. (V3) told me that she and (V4) were working days together prior to the weekend. I didn't know I was tasked to interview (V3) (about the abuse allegations)."

On 11/8/2023 at 9:38 AM, V2 (Former Director of Nursing) said via telephone, she was aware of the incident involving R2 and V4 (Former CNA). V2 said she became aware of the allegation during a stand-up meeting (didn't remember date), when V3 (LPN-Licensed Practical Nurse) reported V4 yelled at R2. "Allegations of abuse should be reported immediately. The resident and aggressor should be separated; the aggressor should be removed from the facility to protect the resident."

On 11/8/2023 at 9:38 AM, V2 (Former Director of Nursing) said via telephone, she was aware of the incident involving R2 and V4 (CNA-Certified Nursing Assistant). V2 said she became aware of the allegation during a stand-up meeting (didn't remember date), when V3 (LPN-Licensed Practical Nurse) reported V4 yelled at R2. V2 said she did not interview V3 about the incident; "she (V3) wasn't specific", she didn't give a date or time. "I know that (V4) was not on duty when it was reported. Allegations of abuse should be reported immediately. The resident and aggressor should be separated; the aggressor should be removed from the facility to protect the resident."

On 11/8/2023 at 10:36 AM, V1 said, "Abuse should be reported immediately, when it happens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

If allegation of abuse is staff to resident, then we would suspend employee immediately. At that moment the priority is the safety of the resident, keep the resident(s) safe. They (the allegations) were reported to me on 10/17/23, and that's when I started my investigation. (V4, Former CNA) was not in the building at the time, so I called (V9, Director of Human Resources) and told (V9) to tell (V4), as soon as she walked in the building, that she was suspended pending the outcome of investigation. I just moved forward with the termination (V4's). Both incidents occurred in the same day; that is a termination. Profanity not allowed; it is abuse." Surveyor asked V1 if telling a resident to "shut up, you're too loud" is abuse, V1 refused to answer, then said, "We'll go with what you're saying. I need to go back and review this (incident) with my regional." V1 said she did not know the date the incidents of abuse happened.

Facility's "Abuse Prevention and Reporting-Illinois" policy (Reviewed/Approved by IDT 12.17.2021) documents:
- "Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation."
-"Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communications, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability."
- "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as administrator in the administrator's absence."
- "Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated."
- "Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual."

Employee Handbook documents: "Each resident also has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. You are required to immediately report all alleged violations involving mistreatment, neglect or abuse, including misappropriation of resident property and injuries of unknown source, to the Administrator or other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003594	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 Facility representative, in accordance with federal and state laws." (B)	S9999		