	T OF DEFICIENCIES OF CORRECTION	: Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
		IL6003594	B. WING		C 05/16/2024	
	ROVIDER OR SUPPLIER	4	DRESS, CITY, S		05/	10/2024
		ORTH 2451 WES	ST TOUHY AV 0, IL 60645			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
S 000	Initial Comments		S 000			
	Complaint Investig	ation 2482966/IL171953				
S9999	Final Observations	3	S9999			
	Statement of Licensure Violations:					
3	1 of 2					
	300.690 b) 300.690 c)					
	b) The facility shall serious incident or Section, "serious" that causes physic c) The facility shall Regional Office wir reportable incident incident or accident resident, the facility law enforcement p notify the Regional purposes of this So Office by phone or Department represe phone that the req Office by phone has unable to contact to notify the Department hotline. The facility summary of each of to the Department occurrence.	acidents and Accidents I notify the Department of any accident. For purposes of this means any incident or accident al harm or injury to a resident. by fax or phone, notify the thin 24 hours after each or accident. If a reportable at results in the death of a y shall, after contacting local ursuant to Section 300.695, Office by phone only. For the ection, "notify the Regional aly" means talk with a sentative who confirms over the uirement to notify the Regional as been met. If the facility is he Regional Office, it shall ent's toll-free complaint registry y shall send a narrative reportable accident or incident within seven days after the ts were not met as evidenced				
ORATORY	ment of Public Health DIRECTOR'S OR PROVI cally Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 06/03/2

Illinois D	epartment of Public	Health			FURIN	APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6003594	B. WING	B. WING		C 16/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
	E CARE CHICAGO NO	ортц 2451 WI	EST TOUHY AV	'ENUE		
ELEVAII	E CARE CHICAGO NO	CHICAG	O, IL 60645			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	Based upon record facility failed to noti	review and interview, the fy IDPH (Illinois Department o prious injury for one of four	of			
	Findings include:					
	was found next to t	dent report states resident he bed, on the floor, lying on timeter) laceration above right	t			
		gress notes state the per side of the right eye was				
	IDPH was notified of fall/laceration at 1:2 stated, "It can't be f	r requested evidence that of R2's (11/27/23) 22pm. V1 (Administrator) ound" and affirmed R2's njury (laceration) was not				
	regulatory requirem V2 (Director of Nurs serious injuries we	m, surveyor inquired about the lent for falls with serious injury sing) stated, "Falls with consider as reportable. We to IDPH within 24 hours for days for final."				
	4/7/19) states an in completed for: all s of residents. The D Director of Nursing, notify the following Illinois Department within 24 hours of the summary of the inc	ccidents policy (reviewed cident/accident report will be erious accidents or incidents irector of Nursing, Assistant or Nursing supervisor must if an actual injury occurs: The of Public Health, by phone he occurrence. A narrative ident is to be sent to the of Public Health within 5 days				

	epartment of Public	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		IL6003594	B. WING	B. WING		C 16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
		2451 W	EST TOUHY AV	ENUE		
ELEVAIE	E CARE CHICAGO NO	CHICAG	GO, IL 60645			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3)					
	a) The facility procedures govern facility. The written be formulated by a Committee consist administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shall by this committee,	esident Care Policies shall have written policies and ing all services provided by the policies and procedures sha Resident Care Policy ing of at least the idvisory physician or the pommittee, and representative er services in the facility. The ly with the Act and this Part. is shall be followed in operating I be reviewed at least annual documented by written, signe of the meeting.	e II s g y			
	Nursing and Person b) The facility care and services to practicable physical well-being of the re each resident's cor plan. Adequate and care and personal	shall provide the necessary o attain or maintain the highe I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to eacl				
	care needs of the r c) Each direct and be knowledgea respective resident	care-giving staff shall review able about his or her residents				

STATEMENT OF DEPICENCIES INDEXTREATION NUMBER       (22) MULTIPLE CONSTRUCTION A BULDING:       (23) MULTIPLE CONSTRUCTION A BULDING:       (24) MULTIPLE CONSTRUCTION A BULDING:       (25) MULTIPLE CONSTRUCTION BULDING:       (26) MULTIPLE CONSTRUCTION BULDING:       (2	Illinois D	epartment of Public	Health			FORM	APPROVED
IL6003594     B.WING     Objic       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       2451 WEST TOUHY AVENUE     CHICAGO, IL 60645       OWING, KORDOW OR LSC DENTFYNG INFORMATION)     PREEX, TOUHY AVENUE       OWING, KORDOW OR LSC DENTFYNG INFORMATION)     PREEX, TAGE ON HOULD BE CROSS REFERENCED TO THE AVENUE CROSS REFERENCED TO THE AVENUE DENTFYNG INFORMATION)     PREEX, TAGE       S9999     Continued From page 3     S9999       OCIDITUDE OF ADDRESS, CITY, STATE, ZP CODE     CROSS-REFERENCED TO THE AVENUE DENTFYNG INFORMATION)     PREEX, TAGE       6)     All neclessary precautions shall be tracticed on a 24-hour, seven-day-aveek basis:     S9999       6)     All neclessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident sead exeloated so the facility, including:     Section 300.1220 Supervision of Nursing Services       b)     The DON shall supervise and oversee the nursing services of the facility, including:     Sources       a)     Developing an up-to-date resident accident hazard in the resident care plan for each reparation of the resident care plan for each reparation of the resident care plan for each reparation of the resident care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.       These requirements are not met as evidenced by:       Based upon record review and interview, failed to mplement appropriate fall prevention interventions; and f	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		COM	PLETED
Bit WEST CULH VAUENUE CHICAGO, LE GOBSSI           PARCH DE VICIACIÓN NUST DE PRÉCEDED BY FULL TAG         D PRÉTIX         PROVIDERS FUAN OF CORRECTION (EACH CORRECTIVE AND SHOULD BE CROSS-REPENDED TO THE APPROPRIATE DEFINITION OF ANY DETAIL TO THE APPROPRIATE DEFINITION OF ANY DETAIL THE DE THE DETAIL TO THE APPROPRIATE DE THE APPROPRIATE DEFINITION OF ANY DETAIL TO THE APPROPRIATE DEFINITION OF A DET			IL6003594	B. WING			
ELEVATE CARE CHICAGO NORTH     CHICAGO, IL 60645       (MUD) PRETX TAG     EXAMPLARY STATEMENT OF DEFICIENCIES EVALUATION ON LISC IDENTIFYING INFORMATION REGULTION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION INFORMATION REGULTION INFORMATION INFORMATION	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG       TEACH DEFICIENCY MUST BE PRECEDED BY FULL REDULTORY OR USC IDENTIFYING INFORMATION)       PREFIX TAG       TAG       COMPLETE DEFICIENCY       COMPLETE DEFICIENCY         S9999       Continued From page 3       S9999         Intrinsing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:       6)       All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.       Section 300.1220 Supervision of Nursing Services       Section 300.1220 Compension of Nursing Services         0       The DON shall supervise and oversee the nursing services of the facility, including: a) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care meded as indicated by the resident's comprehensive assessent's failed to provide supervision to one of four residents (R2) reviewed for fails. These requirements are not met as evidenced by:         Based upon record review and interview, failed to reviewed and indel to provide supervision to one of four residents (R2) reviewed for fails. These failures resulted in R2 sustaining a fail, lacereation (above the right eye), and stitche	ELEVATI	E CARE CHICAGO NO	)RTH		/ENUE		
TAG         RESULATORY OR LISC IDENTIFYING INFORMATION         TAG         CROSS-REFERENCED TO THE APPROPRIATE         DATE           59999         Continued From page 3 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: <ul> <li>All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.                     <li>Section 300.1220 Supervision of Nursing Services</li> <li>Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be reviewed at least every three months.</li></li></ul>	(X4) ID			ID			
nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personal, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by: Based upon record review and interview, failed to revise fail prevention interventions; failed to implement appropriate fail prevention interventions; and failed to provide supervision to one of four residents (R2) reviewed for fails. These failures resulted in R2 sustaining a fail, laceration (above the right eye), and stitches. Findings include:					CROSS-REFERENCED TO THE	EAPPROPRIATE	
following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be inviting and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by: Based upon record review and interview, failed to revise fall prevention interventions; failed to implement appropriate fall prevention interventions; and failed to provide supervision to one of four residents (R2) reviewed for falls. These reguirements evidencies fall, laceration (above the right eye), and stitches. Findings include:	S9999	Continued From pa	ge 3	S9999			
-		following and shall seven-day-a-week 6) All nece taken to assure tha remains as free of a All nursing personn see that each resid supervision and ass Section 300.1220 S Services b) The DON s nursing services of 3) Develop care plan for each n resident's compreh needs and goals to orders, and persons Personnel, represe nursing, activities, o modalities as are of be involved in the p plan. The plan shal reviewed and modifi needed as indicated The plan shall be re- months. These requirement Based upon record revise fall prevention implement appropri- interventions; and f one of four resident These failures resu- laceration (above th	be practiced on a 24-hour, basis: essary precautions shall be t the residents' environment accident hazards as possible. el shall evaluate residents to ent receives adequate sistance to prevent accidents. Supervision of Nursing hall supervise and oversee the the facility, including: bing an up-to-date resident resident based on the ensive assessment, individual be accomplished, physician's al care and nursing needs. nting other services such as dietary, and such other reparation of the resident care II be in writing and shall be fied in keeping with the care d by the resident's condition. eviewed at least every three s are not met as evidenced by: review and interview, failed to in interventions; failed to iate fall prevention ailed to provide supervision to its (R2) reviewed for falls. Ited in R2 sustaining a fall,				
and a Demonstrate of Datable 11 - 10	line in D	Findings include: tment of Public Health					

Illinois Department of Public Health STATE FORM

6899

If continuation sheet 4 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		IL6003594	B. WING			16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ELEVATE	E CARE CHICAGO NO	DRTH	ST TOUHY AV D, IL  60645	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 4	S9999			
	osteomyelitis, low b	lude but not limited to back pain, unsteadiness on of gait/mobility, lack of eakness.				
	The facility incident 10/2/23, 10/12/23 a	reports affirm R2 fell on and 11/27/23.				
		S (Brief Interview Mental a score of 9 (moderate				
		tional assessment affirms R2 I/maximal assistance with ransfer.				
	risk for falls related gait/balance proble Resident is encoura pain medications for transferring to when ensure bilateral floo resident is in bed.	udes (6/14/23) Resident is at to deconditioning and ms. Interventions: (10/3/23) aged to ask for (as needed) or increased pain and before elchair. (11/28/23) Staff will or mats are in place while Resident will be evaluated and by PT (physical therapy) and nerapy).				
	found on floor next Resident reported I phone charger and noted to have smal above his right eye (Emergency Room Resident was broug	gress notes state resident to bed lying on his back. he was trying to reach his slid out of the bed. Resident I 1 cm (centimeter) laceration . Resident transported to ER ) for further evaluation. ght back to the facility, the per side of the right eye was				

STATEME	Department of Public NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		IL6003594	B. WING			C 16/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ELEVAT	E CARE CHICAGO NO	DRTH	ST TOUHY AV O, IL 60645	<b>ENUE</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
S9999	Continued From pa	ige 5	S9999			
	was found next to b back. No witnesses	bed on the floor lying on his s found.				
nois Depa	R2's fall risk assess facility. V2 (Director electronic medical in there's an assessm 26 (moderate fall ris fall prevention inter R2's (10/2/23) fall. V1 to ask for PRN (as increase pain befor 10/3/23". Surveyor intervention was im (10/12/23) fall. V2 r an entry for 10/12" was not revised on inquired about staff falls. V2 stated, "Th care plan." Surveyor (11/27/23) fall/injury responded, "Accord found next to bed of small 1 centimeter Resident was reach slipped out of bed." prevention interven (11/27/24) fall. V2 r be treated with PT (Occupational Ther bilateral floor mats bed." Surveyor inquincluded on R2's fa stated, "I didn't see On 5/14/24 at 2:13p fall prevention. V20 label them (residen	m, surveyor inquired about sment prior to falling in the r of Nursing) reviewed R2's record and stated, "I see that nent 9/11 (2023) the score was sk)." Surveyor inquired what vention was implemented post V2 responded, "Is encouraged needed) medication for re transferring to wheelchair or inquired what fall prevention uplemented post R2's replied, "I haven't seen really and affirmed R2's care plan or about 10/12/23. Surveyor frequirements if a resident ney (staff) need to update the or inquired about R2's y. V2 (Director of Nursing) ding to the note here resident on floor lying on his back has laceration above eye. hing for phone charger and ' Surveyor inquired what fall tions were implemented post eplied, "11/28 it's says (R2) wil (Physical Therapy) and OT rapy) as ordered. Will ensure are in place while (R2) is in uired if staff supervision was Il prevention interventions . V2 that."				

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	epartment of Public	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	······		
		IL6003594	B. WING			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELEVATE	E CARE CHICAGO NO	1RTH	ST TOUHY AV	ENUE		
		CHICAG	O, IL 60645		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ige 6	S9999			
	something." Survey harm to a resident fall. V20 responded hematoma, head tr fractures. Falls car injuries." The fall prevention	f) call, and we implement vor inquired about potential that sustains an unwitnessed I, "You can have a subdural auma, visceral injuries, or n cause many potential program (revised 11/29/22) will include measures which				
	determine the indiv by assessing the ris of appropriate inter supervision and as necessary. The fall the following compe each fall, intervention fall, as appropriate. implemented for eac The resident will be two hours, or as act assure they are in a of safety monitoring	idual needs of each resident idual needs of each resident sk of falls and implementation ventions to provide necessary sistive devices are utilized as prevention program includes onents: Care Plan addresses ons are changed with each Safety interventions will be ach resident identified at risk. e checked approximately every cording to the care plan, to a safe position. The frequency g will be determined by the ors and the plan of care.	,			
	(B)					
	2 of 2					
	300.610 a) 300.1210 b) 300.1210 d)2)					
	a) The facility procedures govern	esident Care Policies shall have written policies and ing all services provided by the policies and procedures shall Resident Care Policy	e			

STATE FORM

STATEMEN	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6003594	B. WING			C 16/2024
	PROVIDER OR SUPPLIER	•	DDRESS, CITY, S	TATE, ZIP CODE		
		2451 WF	ST TOUHY AV			
ELEVAII	E CARE CHICAGO NO	CHICAG	O, IL 60645			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 7	S9999			
	Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shall by this committee, of and dated minutes Section 300.1210 (Nursing and Person b) The facility care and services to practicable physical well-being of the re each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re d) Pursuant to nursing care shall in following and shall seven-day-a-week 2) All treat be administered as These requirement Based upon intervie facility failed to ens was provided to thr R4) reviewed for nu in R2 sustaining sign	ing of at least the advisory physician or the committee, and representatives er services in the facility. The ly with the Act and this Part. a shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting. General Requirements for nal Care shall provide the necessary o attain or maintain the highes I, mental, and psychological sident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident. o subsection (a), general nclude, at a minimum, the be practiced on a 24-hour,	t :			
	Findings include:					

STATEMEN	Department of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6003594	B. WING		C 05/16/2024	
	PROVIDER OR SUPPLIER		J		03/	10/2024
	E CARE CHICAGO NO	2451 WE	EST TOUHY AV			
(X4) ID	SUMMARY ST		i <b>O, IL 60645</b>	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	age 8	S9999			
	upon admission an	physician orders state weigh d weekly x4 for 5 weeks (end 2 was discharged from the				
		S (Brief Interview Mental a score of 9 (moderate				
		tional assessment affirms upervision or touching ing.				
	R2's (5/2/23) admis (pounds).	ssion weight was 202.1#				
	received a call from resident be put on to unsteadiness of	ogress note states writer n resident's parents requesting "feeder" list for assistance due hand while eating. IDT Team) made aware.				
	144# (pounds). IBV Weight over 1, 3, a 12/1/23- 160.6#; 1 Significant weight k unplanned and like	y assessment states weight V (Ideal Body Weight) 190#. nd 6 months is as follows: 0/3/23 - 176# ; 7/23/23 - 187# oss at 1, 3, and 6 months is ly related to poor oral intake a le 1:1 feeding assistance to ke.				
	10/3/23: 176#; 26.1 12/1/23: 160.6#; 41					
nois Depar		<ul> <li>4) documentation survey report</li> </ul>	t			

STATEMEN	epartment of Public	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		IL6003594	B. WING			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	·	
ELEVATE	E CARE CHICAGO NO	1RTH	ST TOUHY A	/ENUE		
		CHICAG	O, IL 60645			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 9	S9999			
	was not documente	sistance for 20 out of 29 meals ed. On 1/1/24 (breakfast & dinner) setup or clean us\p cumented				
	was able to feed his stated, "I know he w don't recall." Surve requested R2 recei responded, "Decen call from the mothe be put on the feedin his hand while eatin	am, surveyor inquired if R2 mself. V16 (Social Service) would drink on his own, but I eyor inquired if R2's family ve feeding assistance. V16 nber 18th is when I received a er; she wanted the resident to ng list due to unsteadiness of ng." Surveyor inquired if was provided to R2. V16 w."				
	blank spaces on th	m, surveyor inquired what e documentation survey report orative Aide) responded, done that day."				
	potential harm to a	pm, surveyor inquired about resident that sustains oss. V20 (Medical Director) Inutrition."				
	residents identified weighed weekly or order or IDT recom may be discontinue remained stable for	revised 10/17/19) states at nutritional risk may be bi-weekly as per physician mendation. Weekly weights ed if the resident's weight has r four consecutive weeks or as IDT, Dietician, or the				
	2.R3's diagnoses ir	nclude quadriplegia.				
	feeding assistance	ary assessment includes 1:1				
ois Depar	tment of Public Health		6899	Q6V11	If continuati	

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	T OF DEFICIENCIES OF CORRECTION	Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		IL6003594	B. WING			C 16/2024
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LEVATE	CARE CHICAGO NO	)RTH	EST TOUHY AV O, IL 60645	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 10	S9999			
	states resident will	ocumentation Survey Report eat all meals with one-person ated, however, 49 of 90 meals ted.				
	-	nclude quadriplegia.				
	R4's (4/19/24) dieta feeding assistance	ary assessment includes 1:1				
		ocumentation Survey Report sistance for 51 of 90 meals ted.				
	includes but is not l					
	(B)					