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S 000	Initial Comments Facility Reported Incident of December 8, 2024 IL184761	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010h) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.3210 t) 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 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

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Based on interview and record review, the facility failing to affirm the right of the resident (R2) to be free from physical abuse and to have a safe environment, resulting in R1 punching R2 in the face. The facility also failed to follow a resident's care plan, failed to follow their seizures policy to assess and document findings and observations of a resident's seizure activity, and failed to send a resident to the hospital for further evaluation who got punched in the face and is on anti-coagulant therapy with active seizures. These failures resulted in R2 crying, and R2 being afraid R1 would attack R2 again.

Findings Include:

R1's face sheet shows R1 has diagnoses including Schizophrenia and Unspecified Intellectual Disabilities.

R1's Minimum Data Set (MDS), dated 11/12/24 and 12/22/24, shows R1 is cognitively intact with BIMS (Brief Interview for Mental Status) score of 15, and has the ability to walk.

R1's behavior care plan documented: (dated initiated 3/21/2019) R1 displays behavioral symptoms related to severe mental illness. These are manifested by rummaging, or taking food off of food carts, or unattended food. R1 may become agitated when redirected and display aggressive behavior. R1 demonstrates behavioral distress as manifested by yelling to towards staff, residents physically abusive behavior when agitated; attempting to push, shove, scratch, or otherwise harm another person. This behavior occurs 1-3 times per week and is related to being challenged by mental illness, ineffective coping mechanisms.

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R2's face sheet shows R2 has diagnoses including Hemiplegia Affecting Right Dominant Side, Vascular Dementia, Schizoaffective Disorder, Anxiety Disorder, Right Hand Contracture, and Epilepsy.

R2's Minimum Data Set/MDS, dated 11/24/25, shows R2 has moderately impaired cognition with BIMS (Brief Interview for Mental Status) of 12, and requires substantial maximal assistance from staff with activities of daily living. R2's December Medication Administration Record shows R2 is receiving anticoagulant therapy; Heparin injection every 12 hours.

R2's comprehensive care plan documented R2 has Seizure Disorder (date initiated 4/22/2019). Interventions include Post Seizure Treatment: After seizure take vital signs and neuro check, monitor for aphasia, headache, altered level of consciousness, paralysis, weakness, pupillary changes. Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity.

R2's progress notes, dated 12/8/24 at 1:28 PM, documented by V11 (Agency Nurse) reads: "(R2) was involved with another patient's behavior issue. (R1) was eating lunch wanted more food so (R1) walked to the cart in the hall. (R1) did not see a tray that he could take off the cart so (R1) started pulling used trays off the cart in anger. (R1) walked to the nurses' station and started throwing things. (R2) was sitting at the nurses' station eating and being observed due to fall risk when it was reported that (R1) struck (R2). Both patients were immediately separated and (R1)

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was placed on one-one observation. NP (Nurse Practitioner) and Family were made aware and (R2) was given a shot of Ativan to calm (R2) down and reported seizures noted following incident. (V10, Assistant Director of Nursing) and all other necessary parties made aware."

The facility's final abuse reportable sent to the State Agency (SA) documented: "Incident date was 12/8/24 at 1:05 PM. Based on a complete and thorough investigation, (R1) had just finished with his lunch and brought his lunch tray back to the food cart for collection, as per his routine and baseline. (R1) was still hungry and instead of asking the staff for more food from the kitchen, he stated he thought he would look for an extra tray on the cart that he could take food from. (V8, Former Certified Nursing Assistant/CNA) saw (R1) attempting to take someone else's tray of food and asked (R1) if he was still hungry, he could get him another tray or plate of food. Politely, (V8) also asked (R1) to please not take any food off the trays on the cart as they belong to other residents. Suddenly, (R1) became upset and walked away. (R2) was near the area of the event and as (R1) walked away, (R1) abruptly made unwanted contact with (R2) using an open hand. (V8) witnessed the incident and immediately separated (R1) from (R2). (R1) apologized at that moment and was assisted back to his room, kept under direct supervision, and was also provided with a new tray of food as per (R1's) request."

R2's clinical records do not show any documentation of R2's assessment findings and observations of R2 during and after R2's seizure activity. No documentation of vital signs, the type of seizure, R2's level of consciousness, the duration of the seizure, if neuro checks were

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done, and if R2 was monitored for any other acute changes in condition. R2's clinical records also do not show documentation if R2 was sent to the hospital for further evaluation post seizure activity after being punched by R1.

V8's witness statement from the facility's investigation, dated 12/8/24, documented, "(R1) was going through the lunch trays. I told (R1) to stop. (R1) got upset and began throwing trays off the cart and throwing a box at me. (R1) went to (R2) who was sitting eating (R2's) lunch and hit (R2). (V17, Certified Nursing Assistant) tried to stop (R1) and once we attmepted to redirect and get the nurse (R1) apologized."

On 1/26/25 at 9:54 AM, R2 stated R2 does not remember another resident punching R2 on the face. R2 stated, "I don't remember that incident. I usually remember something like that, but I don't remember." R2 stated R2 knows R2 is forgetful. R2 stated R2 had stroke and has had many seizure episodes. R2 stated R2 does not walk anymore and R2's right side is paralyzed.

On 1/26/25 at 10:01 AM, R1 stated, "I'm upset. I always get upset. When I'm angry, I hit people." When surveyor asked R1 to clarify what R1 had just said, R1 repeated the same answer, "I'm upset. I always get upset. When I'm angry, I hit people." R1 stated R1 is not angry or upset now, but R1 refused to answer further interview questions.

On 1/26/25 at 11:09 AM, V8 (Former CNA), stated, "It happened around lunch time the incident was about the lunch tray. (R1) wanted to dig in and I told him to stop twice; the third time (R1) got upset. (R1) ran over to me. (R1) threw everything at me whatever he could grab from the

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nurses' station. I did not give (R1) any reaction. I just stood there and looked at (R1). I was just looking at (R1). (R1) didn't stop and when (R1) saw that I was not reacting to his behavior, (R1) went straight to (R2) and punched (R2) in the face. (R2) cried. (R2's) face was really red from the punch. (R2) was sitting on a geri (geriatric) chair by the nurses' station because we would always put (R2) there to closely monitor him because (R2) has history of seizures. (R2) was crying and (R2) said that he was scared that (R1) would come back and attack (R2) again. (R2's) face was red. When this happened, I immediately go get the nurse. They were agency nurses; they told me to call the ADON (V10, Assistant Director of Nursing). I went back to the nurses' station and saw (R1) was trying to throw food at (V17, CNA). I called the ADON and was told to call the police. I called the police and then the ADON came up and talked to (R1). Right after this incident, a few minutes later after (R2) got punched, (R2) had seizures. I don't know who checked on (R2)."

On 1/26/25 at 3:21 PM, V8 verified R1 came up to R2 and intentionally punched R2 in the face because R1 had seen V8 did not react to R1's aggressive behavior. V8 stated after R1 punched R2, R1 apologized. V8 stated R1 punching R2 is a type of physical abuse because R1 hit R2 knowing R2 could not move and could not defend himself.

On 1/26/25 at 11:23 AM, V17 (Certified Nursing Assistant) V17 stated V17 did not witness the initial incident. V17 stated, "I was passing by and I heard (V8) telling (R1) to stop. I saw (R1) angry and (R1) was trying to throw food at me. I backed away. I went to go ask for help. I called (V8) back and told (V8)."

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On 1/26/25 at 12:27 PM, V10 (Assistant Director of Nursing/ADON) stated V10 was doing rounds in the building, and was stopping on the fourth floor, and the staff was saying to V10 that R1 had just hit R2 in the face. V10 stated V10 instructed the staff to immediately separate R1 and R2. R1 was placed on one-on-one supervision and R2 was assessed. V10 stated V10 assessed R2 with the nurse, but does not remember which nurse. V10 stated R2's face was slightly red, but no open wounds. V10 stated originally, R2 said he was okay, but then R2 said R2 was anxious and nervous about R1 hitting R2. V10 stated R2 did not say R2 was scared. V10 stated approximately 6 minutes after the incident, R2 had two seizures that lasted for 4 to 5 minutes. V10 stated, "The whole time (R2) was shaking but still able to make conversation. (R2) was alert. (R2) had seizures at least twice. Both times (R2) was alert. The nurse assessed (R2) after the seizures. The Nurse Practitioner (NP) was in the building. I don't know what time (V9, In-House NP) saw (R2). I told the agency nurse that (V9) was in the building. I also called (V9). I did not document; I hope the nurse did. The standard nursing practice is that the nurse should be documenting the services and the interventions provided. If it's not documented there is no documentation to support that the interventions and services were rendered. I don't remember if (R2) was sent out to the hospital after the seizures."
On 1/26/25 at 10:08 AM, V7 (Certified Nursing Assistant) stated R1 has impulsive behavior. V7 stated R1 would throw stuff when R1's mad. V7 stated R1 is not always mad, but when R1 gets upset, R1 would try to hit people, like staff or other residents. R1 needs to be re-directed when he's upset because when R1's upset he would be throwing things and try to hit other people. V7 stated it's R1's behavior ever since and R1 has a

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history of getting physically aggressive with staff and residents when R1's upset.

On 1/26/25 at 11:01 AM, V16 (Social Service Director). stated R1 is alert and oriented times 3-4 (person, place, time, event) and is "pretty aware". V16 stated R1 has little bit of anger/temperament issues at times when R1 is confused and overstimulated. V16 stated R1 gets agitated at times and requires re-direction if R1's unfamiliar with staff; sometimes R1 has been known to grab trays. V16 stated R1 had history of being agitated and if that happens, staff needs to provide brief one on one with R1. V16 stated when R1 is agitated, "Staff needs to remove (R1) from the situation and provide one to one counselling to calm (R1) down. Talk to (R1). (R1) is usually able to tell you. (R1) will most likely apologize. (R1) has impulsive behaviors and has problem solving impairment. If (R1's) upset or agitated, right away, staff needs to calm (R1) down and talk to (R1) and re-direct (R1). For example, tell (R1) to come walk with me or talk to me. If you don't address the behavior or try to talk back with (R1), it will become worse. It will continue to escalate (R1's) anger."

On 1/26/25 at 11:53 AM, V2 (Director of Nursing) stated V2 was notified R1 inadvertently hit R2 in the face. V2 stated R2 had a seizure after the incident. V2 stated V2's expectation is that after a resident's seizure activity, the nurse should check the resident's vital signs, keep the resident safe, and call emergency (911). V2 stated even if the seizure stops and seems the resident is stable, every time they have a seizure they have to call 911. V2 stated V2 does not remember if R2 was sent to the hospital after the seizure. V2 stated, "If we don't send the resident to the hospital after the seizure then we won't know if they potentially

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have other complications from the seizure. We won't know how bad the seizure was." V2 (Director of Nursing) stated abuse is anything that puts the resident in an intentional harm. The types of abuse are physical, verbal, sexual, financial, emotional. V2 stated an example of physical abuse is hitting a resident.

On 1/26/25 at 2:29 PM, V1 (Administrator) stated the residents have all the right to be safe in the facility, to be able to be free from abuse and feel at home, and state anything without any repercussion, and be part of their care. V1 stated if there is a resident-to-resident altercation, the residents should be separated immediately. V1 stated the incident that happened between R1 and R2 on 12/8/24 was not a form of physical abuse, because R1 acted unintentionally. V1 stated the reason why R1 and R2 were not sent out to the hospital for further evaluation was because V1 feels like it was not a form of abuse based on V1's investigation.

On 1/26/25 at 2:46 PM, V10 (ADON) stated V10's mind was not clear during the first interview, and V10 provided the wrong information. V10 stated V10 notified V18 (Nurse Practitioner) of R2's seizure activity on 12/8/24, and not V9. However, V10 stated V10 did not also document this notification and did not document what was ordered by V18. V10 stated V10 texted V18. R2's progress notes also do not show any documentation from V18 that V18 was notified of the incident and R2's seizure activity on 12/8/24.

On 1/26/25 at 3:00 PM, V2 and asked to clarify what is documented on the facility's Seizure policy. V2 stated, "It means that if a resident experiences a seizure activity, the nurse should assess and document the resident's vital signs,

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any changes, any vomiting, the type of seizure, the resident's cognition, if they lose consciousness, respiratory condition, and if the resident is in distress." V2 stated the complete assessment and observation should be documented in the resident's electronic chart.

On 1/26/25 at 3:06 PM, V9 (In-House Nurse Practitioner/NP) and stated V9 was not notified of R2 being punched by R1 in the face. V9 also stated V9 was not notified of R2's seizure activity after the incident. V9 stated V9 was in the facility on 12/8/24 because V9 is the weekend in-house NP. V9 stated if V9 was notified of R2's seizure activity and being punched in the face, V9 would order for R2 to be sent out to the hospital for further evaluation because R2 is on anticoagulant therapy. V9 stated, "It is the same protocol if a resident falls and is on anticoagulants. We need to send the resident out to the hospital for their safety. They need to be checked and conduct further testing to see if the resident sustains other complications." V9 also stated after seizure activity, the nurse should be documenting how long was the seizure lasted, what type of seizure, and what was the condition of the resident. V9 stated V9's documentation on R2's progress notes on 12/8/24 was to follow up about the fall, and not about the seizure activity or the incident with R1

On 1/27/25 at 11:35 AM, V11 (Agency Nurse) and stated, "I just remember that I was called by the CNA I don't remember who was the CNA. I was told that (R1) struck (R2) in the face. I did not witness it. After the incident (R2) had seizures. I was with (V10) and she contacted the Nurse Practitioner. I don't know who (V10) contacted. I don't remember if I did an assessment on (R2). I would have documented the assessment in the

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progress noes if I did."

The facility's Abuse Prevention and Reporting policy, dated 10/24/22, documents: "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 or property, and mistreatment of residents. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."

The facility's "RESIDENTS' RIGHTS" policy (undated) documents: The residents have the right to safety, must not be abused and residents' facility must be safe, clean, comfortable and homelike.

The facility's "Seizures" policy (no date) documents: Initial and ongoing clinical assessments will determine the potential of seizure activity. Nursing Intervention: When seizure is over obtain vital signs (Auxiliary temperature) and position onto side. Notify physician and follow orders. Administer CPR if breathing ceases - call 911. Document findings and observations in the resident's clinical record including notification of physician and responsible

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 01/27/2025

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 party. (B)	S9999		