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 06/13/2025

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
S 000	Initial Comments Complaint Investigation 2585220/IL194166	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1220 b)8) 300.3240 a) 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 300.1210 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	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 06/13/2025

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 1	S9999		

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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

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)

These requirements are not met as evidenced by:

Based on interview, and record review, the facility to ensure two [R1, R2] of five residents sampled was free of abuse from an employee, and failed to implement and maintain an effective abuse training program for one [V5] of three employees reviewed for abuse. These failures resulted in R1 sustaining swollen discolored lips and pain, and R2 experiencing increase in pain and mental anguish.

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 06/13/2025

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 2	S9999		

Findings Include,

1. R1's clinical record indicates R1 is a seventy-one-year-old, admitted with hemiplegia, hemiparesis following cerebral infarction affecting right dominant side, dysphagia, type II diabetes, vascular dementia, major depression, abnormal posture, lack of coordination, abnormal posture, gait and mobility, essential hypertension.

R1's Minimum Date Set [MDS] section [C] indicates R1 is moderately cognitively intact. MDS section [GG] indicates R1 requires maximum assist with ADL care, transfers, and mobility in bed with repositioning.

R1's Care plan documents:
On 6/6/25, R1 reported physical abuse.
R1 will benefit from restorative program due to generalized weakness, impaired mobility, and physical limitations.
R1 is a fall risk: [2/28/25] applied bilateral floor mats when R1 is in bed.
R1 is dependent with ADL care, turning and repositioning, sit to lying, and sit to stand.
R1 requires use of full body lift for transfers.
R1 will be treated with respect, dignity, ad resides in the facility free of mistreatment.

R1's Progress notes documented:
6/6/2025 at 6:25 PM, Nurses Notes [V8, Registered Nurse]
Note Text: R1's bottom lip was swollen. Notified the family and nurse practitioner [V10].

R1's IDPH [Illinois Department of Public Health] Reportable, dated 6/11/25, documents:
"Investigation completed. During nursing rounds [R1] alleged [V5, Certified Nurse Assistant] hit her while she was helping her with care. [V5] 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 06/13/2025

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 3	S9999		

immediately suspended. Interview with [R1] stated while she was receiving care from [V5], [R1] pulled the hair of [V5] and did not let go until [V5] pushed herself away. That is when [R1] was hit in the lip. No other staff or resident was in the room at the time. Based on the report by [R1], the facility will substantiate abuse."

R1's 6/6/2025 6:22 PM V10, Nurse Practitioner, Progress Notes
"Late Entry: Swollen Right lip and jaw, follow up visit for acute and chronic medical conditions. HPI: 71-year-old female with a past medical history of ischemic stroke with no residual neurological deficit and hypertension. 6/6/25, [R1] was seen and examined due to being notified of right swollen lip and jaw due to possible fall. After interviewing the patient, [R1] claims that she was being changed by the CNA and she felt the CNA was being a little rough, so [R1] pulled the CNAs hair and yanked it down, then the patient explained that right after that the CNA punched her in the right side of her face. Right lip and jaw were swollen and bruised but [R1] could still talk and open/close her mouth, Eating meals. Will continue to monitor, notified Administrator [V1] and V2 [Director of Nursing]."

R1's 6/10/2025 11:49 AM Nurses Notes:
Note Text: "[R1] complained of pain in the lips, assessed and discoloration noted, Tylenol given as ordered, ice pack placed on the lips checked within normal limit."`

R1's 6/11/2025 1:00 PM, V10, Nurse Practitioner Progress Notes
"Follow up Swollen Right lip and jaw, follow up visit for acute and chronic medical conditions on 6/11, [R1] still complaining of right jaw pain, right lip swelling is improved, [R1] remains stable,

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 06/13/2025

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 4	S9999		

Ordered Facial XR (x-ray) for facial bones. Results acute ischemic infarct resulting in LLE weakness and mild dysarthria history of multiple ischemic strokes in the past, and Vascular dementia."

On 6/11/25 at 1:50 PM, surveyor R1's right side of lip with light colored red area noted. R1 stated, "On Friday, [V5] was cleaning me up and changing my linen tossing me from side to side. I was hurting, and I told [V5] to stop pushing me hard on my side. I started yelling for [V5] to stop, but [V5] kept going. I reached up and was able to get hold of her hair then I pulled it, only to make her stop hurting me. Then [V5] took her fist and punched me in the mouth so hard it took my breath away. Once she punched me, she ran out of my room. Another nurse aide came into my room, and I told him what happened, then the nurses came in to check on me. My mouth and lips were hurting ever since Friday. My lips were swollen, black, blue, and bleeding."

On 6/11/25 at 2:00 PM, R5 stated, "On Friday when [R1] was beat up, I was not in the room, I was in the day room. I left out the room when [V5] came to clean [R1] up. Then once I returned, [R1's] mouth was swollen really bad and was black and blue. I was in shock, to see how bad [R1's] face looked. [R1] told me [V5] punched her in the mouth."

On 6/12/25 at 11:00 AM, V6 [R1's Family Member] stated, "Friday morning, I received a phone call from [V8, Registered Nurse]. V8 told me [R1] had a swollen bottom lip and administration will investigate the cause of the swelling. [R1] is alert and oriented x3; due to the stroke sometimes her speech is not clear on some days. Some people mistake her word delay

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 06/13/2025

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 5	S9999		

for cognitive deficit, but that is not true. The next day I spoke with [R1] over the phone. [R1] said [V5] was cleaning her up and moving back and forth roughly, causing her pain to increase. [R1] said she was yelling out telling [V5] to stop, but she kept on being rough. So, [R1] grabbed [V5's] hair to make her stop, then [V5] with a closed fist punched [R1] on the side of her mouth and jaw. Saturday, I went to visit with [R1] and noted her lips swollen, black, and blue. There was not anyone for me to speak with on Saturday. On Monday I spoke with [V1, Administrator] and he told me basically the same story and he was investigating the allegation of abuse. I am a retired police officer. The facial trauma [R1] had definitely came from a facial punch, not from [R1] sliding out the bed onto the mats on the sides of her bed. Due to [R1] having a stroke, half of her body is paralyzed. [R1] is unable to stand up, she only can slide out the bed onto her floor mats. [R1] would not have got that type of injury from a slide and fall. I did not request [R1] to be sent to hospital. [V10, Nurse Practitioner] called me and gave me an update on his assessment."

On 6/12/25 at 1:00 PM, V10 [Nurse Practitioner] stated, "I am [R1's] nurse practitioner. I was in the facility the day of the incident. When I assessed [R1], her lip and jaw was swollen there was redness, blue purplish discoloration in the lip area noted. [R1] told me that [V5] was rough during care, and that she told [V5] to stop, but [V5] kept going, then [R1] grabbed [V5] hair and [V5] punched her [R1] in the right jaw, lip area. Once I assessed [R1], she could talk and eat, and did not have any acute findings. I ordered a facial X-ray no concerns of fracture. During my assessment, there was no active bleeding, however, I did see a tiny scab on the upper right lip was noted, but no active bleeding at that time.

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 06/13/2025

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 6	S9999		

I did not send [R1] to the hospital because my assessment did not show any acute findings was going on, and there was no suspicion of a fracture. [R1's] still having residual pain and hurts mildly when she's chews. [R1] said it was mild pain and receives Tylenol for pain as needed. I saw [R1]; today the swelling has decreased, and she says she's feeling much better today. On 6/6/25, I notified administration about the allegation of abuse and my assessment on the injury. I did not get any notifications that [R1] had any fall on 6/6/25."

On 6/12/25 at 2:18 PM, V8 [Registered Nurse] stated, "I am new nurse, received my license a month ago. [R1] is alert and oriented x2-3, able to express herself to make her needs known. [R1] mostly stays in bed and needs maximal assistance with ADL care, repositioning, and transfers. I was [R1's] nurse on 6/6/25. I administered [R1's] morning medications, and there was no swelling nor bruising noted on [R1's] face. [V5] did not tell me that [R1] slid out her bed on to the floor mat. I would have assessed [R1], completed incident report, and make [V2, Director of Nursing] and [R1's] family member [V6] aware. Around 3:30 PM, a second shift certified nurse assistant told me to come look at [R1's] face. I observed [R1] with a significantly swollen lips that was black, blue, and purplish in color. [R1] was visibly upset and said [V5] was providing care and being rough, causing an increase in pain. [R1] said she yelled out to [V5] telling her to stop a few times, but [V5] kept pulling and pushing her from side to side, so [R1] said she reached up a grabbed [V5's] hair as [V5] was pushing her to [R1's] side. [R1] said [V5] got really upset, and then [V5] punched her [R1] in the mouth with her [V5] fist. I took [R1's] vital signs, and applied an ice pack on [R1's] mouth area. I notified [R1's]

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 06/13/2025

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 7	S9999		

nurse practitioner [V10]; he was in the facility, phoned [R1's] family member [V6]. I also told the manager on duty [V9] and he called the Administrator for me. [V5] did not report to me that [R1] grabbed and pulled her hair. [V5] did not report any incident regarding [R1]."

On 6/12/25 at 2:48 PM, V9 [Director of Restorative/Licensed Practical Nurse] stated, "On 6/6/25, around 4:00 PM, [V8] notified me that [R1] said [V5] punched her in the face. I went to [R1's] room, and I saw [R1's] lips on the side was swollen and were discolored dark purple, blackish color. [R1] told me [V5] was hurting her during ADL care turning her back and forth hard, and asked [V5] to stop several times, but [R1] said [V5] kept going. [R1] said she then grabbed and pulled [V5's] hair to make her stop. [V5] punched her in the face with her [V5] fist. I then immediately called [V5] to the reception desk and asked her what happened. [V5] did not say nothing. [V5] punched out and left the facility. I notified [V1, Administrator]. I was instructed to call the police, and the police report was made. [R1] is alert and oriented x3, she has never made any allegation of abuse before."

On 6/12/25 at 4:35 PM, V2 [Corporate Interim/Director of Nursing] stated, "I been in this facility since April 2025. I was on vacation during the time of]R1's] incident on Friday, 6/6/25. I returned on Tuesday and learned about the allegation of abuse. I went to see [R1]and observed her lower lip swollen purplish in color. I asked [R1] was she okay, she responded yes. I did not ask [R1] what happened, I did not want to trigger her trauma. I had nothing to do with the investigation."

On 6/12/25 at 4:50 PM, V3 [Assistant Director 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 06/13/2025

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 8	S9999		

Nursing] stated, "I was made aware 6/6/25 by [V9], that [R1] alleged [V5] punched her [R1] in the mouth. [V5] was suspended and sent home. I made [V2, Director of Nursing] aware and [V1, Administrator]. I saw [R1] on Monday, 6/9/25, and noted [R1] with swollen lips, dark in color. I sent a message to [V2, Director of Nursing] in regard to the allegations."

On 6/13/25 at 10:22 AM, V5 [Certified Nurse Assistant] stated, "I was working a double shift on 6/6/25. First shift I worked on the first floor with [R1]. On 6/6/25, around 9AM, [R1] slipped out of bed like she normally does. [R1] was observed lying on the floor mat next to her bed face up. I assisted her back to bed; nothing was wrong with [R1's] face. I told [V8, Registered Nurse] but [V8] said she was too busy, and for me to put [R1] back into bed. After lunch around 1PM, I went to provide ADL care to [R1], and she needed a linen change. There was nothing wrong with [R1's] lips or mouth area. During ADL care, out of nowhere, [R1] grabbed my hair and pulled down. When [R1] finally let go of my hair, I left out of [R1's] room and reported the situation to [V8]. After the incident, I never went back into [R1's] room. Later, I was working second shift on the third floor, when I was paged to come down into to the lobby. [V9, Restorative Nurse] the manager on duty, asked me what happened between me and [R1]. I told him the same story. [V9] told me that I was suspended pending abuse investigation. I punched out and left the facility. I did not hit [R1] on her face, lips, mouth or anywhere. I am familiar with [R2]. I did not have any conflicts with [R2]. I have never been rough while providing care to [R1] nor [R2]. I did not receive abuse training. I do not know who the Abuse Coordinator is for the facility. I started working at the facility April 2025."

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 06/13/2025

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 9 On 6/13/25 at 1:20 PM, V11 [Certified Nurse Assistant] stated, "I worked on Friday, June 6th, and I did not hear any yelling from [R1's] room. I did not see any swelling or bruising on [R1's] mouth on 6/6/25, but I was not [R1's] CNA on that day. I am familiar with [R1]; she is alert, oriented x3. [R1] requires extensive assist with ADL care, repositioning and transfers, due to her being paralyzed on one side. [R1] is not able to stand up or walk. There are times [R1] slides out of bed. We all make sure the floor mats stay in place to prevent any injuries. I received abuse in-service a couple of weeks ago. The abuse coordinator is the administrator." On 6/11/25 at 11:20 AM, V4 [Human Resource/Corporate Interim] stated, "I been in human resources for five years. I been in this facility since 5/28/25. [V5] was hired on 4/22/25, After careful review of [V5's] employee file, [V5]did not receive Abuse training upon hire, during orientation, nor the course of her [V5] employment. All staff is to receive abuse training and prevention upon hire before working with residents. The abuse training should be maintained in the employee's file." On 6/12/25 at 4:45 PM, V1 [Administrator] stated, "I am the Abuse Coordinator of the facility. All employes are required to received abuse training, reporting and prevention upon hire prior to the employee working with the residents. The Abuse training is to prevent abuse from occurring and teaching the employee how to respond appropriately to aggressive residents. If an employee does not receive abuse training, it could potentially increase the risk for abuse. The abuse training should remain in the employee file."	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 06/13/2025

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 10	S9999		

2. R2's clinical record documents R2 is a seventy-year-old, admitted with hemiplegia, hemiparesis following cerebral infarction affecting left side, dysphagia, chronic obstructive pulmonary disease, abnormal gait and mobility, lack of coordination, abnormal posture, essential hypertension, reduced mobility, and muscle wasting.

R2's Care plan documents:
R2 has deficit in bed mobility due to generalized weakness, impaired gait, balance, pain secondary to CVA and left sided hemiparesis.
R2 will be treated with respect, dignity, ad resides in the facility free of mistreatment.

R2's IDPH Initial Reportable, dated 6/12/25, documents:
"[R2] is alert and orientated x3. During rounds with IDPH surveyor, [R2] reported that [V5, Certified Nurse Assistant] ate his food a few times, was rough when giving care, and verbally rude many times when interacting with [R2]. [V5] was suspended previously due to investigation. [R2] was told [V5] no longer works at the facility. [R2] has no distress and feels safe in the facility. Family and physician made aware. Police department made aware. Full report to follow."

On 6/12/25, at 4:30 PM, during rounds with V1 [Administrator] R2 stated, "I remember [V5]. Her and my niece have the same name. I would place on my call light, and she would barge into my room and say 'what do you want', being so rude and disrespectful all the time. I told [V5] that I was going to tell my family that she was so rude and hurts me when providing care. [V5] said that was fine, and have my family come wipe my a**.

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 06/13/2025

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 11	S9999		

When [V5] provided ADL [activities of daily living] care, she would push me on my side rough and hard, which would increase my pain. One day I received my food tray around 12 noon. [V5] came into my room before I could eat, she removed my food tray. On those days, I just didn't eat. [V5] was very cruel, mean, disrespectful, and [V5] was being rough, caused me to have pain. [V5] was physically and verbally abusive to me more than once. It made me feel bad about myself, sad, less than a man. I am here because I need the help, not to feel terrible about myself. I don't want [V5] to care for me anymore. I told you [V1/ Administrator] a few days ago, how [V5] provided care to me, I told you everything."
V1 stated, "I do not recall you [R2] telling me this information, I will investigate, complete and send in the IDPH reportable today."

On 6/12/25 at 4:45 PM, V1 [Administrator] stated, "The incident occurred on 6/6/25, on first shift, approximately 2PM. [V8, Registered Nurse] was [R1's] nurse and was supervising [V5, Certified Nurse Assistant]. A 3PM-11PM Certified Nurse Assistant told [V8] that [R1's] mouth was swollen and bruised, and [R1] said [V5] punched her in the mouth. [V8] assessed [R1] with the manger on duty, [V9, Director of Restorative Services], and [V9] notified me of the allegation of abuse. [V5] was immediately suspended and left the facility. [R1] told me during ADL care with [V5], she [R1] pulled [V5's] hair due to [V5] being rough, then [V5] hit [R1] on the lip. I completed the IDPH reportable. [V5] was interviewed, and said [R1] did pull her hair, but said she did not hit or punch [R1], and does not know how [R1's] lip was injured. Inservice of abuse prevention and reporting were given to staff. [R2's] allegation of abuse from [V5]; a reportable to was sent into IDPH today, and I started an investigation. Based

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 06/13/2025

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 on the report from [R1] and the injury, the facility will substantiate that the alleged abuse happened, and [V5] was terminated today [6/12/25]. All staff received abuse training on 6/9/25." Policy documented: Abuse Prevention and Reporting Policy dated 10/24/22. This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods, physical, sexual, mental, verbal, unreasonable confinement, and involuntary seclusion. 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. This also includes the deprivation by an individual including a caretaker of goods or services that are necessary to attain and or maintain physical, mental or psychosocial well -being. Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: What constitutes abuse. How to assess, prevent and manage aggressive, violet reactions of residents in a way that protects both the resident and staff. (B)	S9999		