

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation:						
	2597824/IL2593372						
	2597884/IL2595638						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)6)						
	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						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 1 the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 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. These requirements are not met as evidenced by: Based on interviews and record reviews, the facility failed to develop and implement a care plan for a resident with documented history of dysphagia, despite recommendations from speech therapy that resident should have swallowing precautions in place; and failed to follow policy and guidelines in performing emergency procedures during life-threatening situations. These deficiencies affected one (R1) of four residents reviewed for accidents and supervision. As a result, R1 was allowed to eat independently, experienced a choking incident, and subsequently died in route to the hospital for emergency care. Findings include: R1 is a 78-year-old, female, admitted in the facility on 07/18/25 with diagnoses of Acute Respiratory Failure with Hypoxia; Dysphagia, Oropharyngeal Phase; Chronic Obstructive Pulmonary Disease with Acute Exacerbation; and Mild Cognitive Impairment of Uncertain or Unknown Etiology. R1's MDS (Minimum Data Set) dated 07/28/25 recorded the following:		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 2 Section (Sec) C – BIMS (Brief Interview for Mental Status) score is 14, which means little to no impairment in cognition. Sec. GG – Functional Abilities: A. Eating – 04, which means supervision or touching assistance. Helper provides verbal cues and/ or touching/steadying and/ or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Sec. I – Active Diagnoses: Additional Active Diagnosis - Dysphagia, Oropharyngeal Phase Sec. K – Swallowing/Nutritional Status: K0100 Swallowing Disorder - B. Holding food in mouth/cheeks or residual food in mouth after meals; D. Complaints of difficulty or pain with swallowing. R1's care plan documented: Requires set-up or clean-up assistance to substantial/maximal assistance in her functional mobility and ADLs such as bed mobility, transfer, toileting and eating, dressing, bathing and personal hygiene related to fatigue, generalized weakness and SOB (shortness of breath): Interventions: Resident (R1) usual performance: Eating – Supervision or touching assistance. POS (Physician Order Sheet) dated 07/20/25 documented R1 is on general diet, regular texture, thin consistency, no red meat. POS dated 07/21/25 recorded in part but not limited to the following: ST (Speech Therapy) evaluation and treatment 3-5x/week for 41 days, to address R1's dysphagia. Aspiration and reflux precautions. Progress notes dated 08/04/25 documented R1 was noted with difficulty swallowing after swallowing piece of burger. It also stated that R1 is already under ST (speech therapy) evaluation. ST (Speech Therapy) service date 07/21/25, re-evaluation 07/22/25 recorded in part but not limited to the following: Skilled ST to address dysphagia and to improve safety of oral intake provided. Proceed with m/s (mechanical soft) and thin liquids with strict		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 3 aspiration precautions and ongoing assessment of swallowing function as medical necessary. On 08/25/25 at 3:25 PM, V7 (Speech Therapist) was asked regarding R1. V7 stated, "She is alert. I reached out to V19 (Family Member) and based on his (V19) information, she (R1) has difficulty swallowing, therefore we prescribed liberalized diet with no red meat, and she (R1) is ok with turkey and chicken. I informed dietary regarding diet. I recommended to proceed with requested diet, no red meat. She refused video swallow test, and he (V19) was informed. I recommended to eat slowly with small bites, small sips. She (R1) is on full aspiration precautions due to long history of dysphagia." Facility's incident report documented that on 08/12/25 while assigned CNA (Certified Nurse Assistant, CNA) was supervising R1 have dinner, she (R1) began to have difficulty breathing, signaling for help. CNA immediately performed abdominal thrusts and call staff for help. Assigned RN (Registered Nurse) and other nursing staff on the unit responded immediately. R1 was able to expel ingested food and was placed on supplemental oxygen with no loss of consciousness. R1 was able to verbalize she is okay. Paramedics arrived and took over. R1 was alert, responsive and breathing via nonrebreather mask with SpO2 (saturation of peripheral oxygen) level of 97% when picked up by paramedics. R1 was sent to the emergency room for further evaluation. R1's Ambulance Report dated 08/12/25, time stamped 5:13 PM, documented: Mental status – unresponsive Narrative: Ambulance was dispatched to the above location for the choking. Upon arrival, patient (R1) was found unresponsive laying in bed. Facility staff reported the patient (R1) was eating and then started to choke on the food. Facility staff attempted to do the Heimlich maneuver and suction, but they were only able to get some pieces of food out. Crew noted a SpO2 of 60%. Patient (R1) had a NRB (nonrebreather mask). Crew asked facility if the patient (R1) had a DNR (do not resuscitate) but one was not able to be answer or provide one right away. Patient (R1) was moved to cot and secured and taken to ambulance where vitals were obtained. Crew noted a SpO2 of 48%, BVM (bag valve mask) with supplemental oxygen was placed on patient; crew assisted with manual respirations. Reassessed SpO2 was 94% with BVM. 4 lead EKG (electrocardiogram) obtained and showed sinus brady. IV (intravenous)		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 4 attempted and established in the left AC (antecubital), with a 18 G (gauge) and saline lock. City fire department came to ambulance with a valid DNR. Hospital was contacted, no orders or questions. En route to hospital, crew noted patient did not have a radial or carotid pulse. No CPR (cardiopulmonary resuscitation) was initiated due to valid DNR. Hospital records dated 08/12/25 recorded: The pertinent facts of this case are 78-year-old female (R1) who presents with respiratory arrest. Patient (R1) brought by EMS (emergency medical service). Patient (R1) was reportedly eating at mealtime at long-term care facility when she began to have a choking episode. Staff attempted Heimlich maneuver without relief. EMS was contacted, on scene report that patient (R1) was continuing to have difficulty breathing and speaking, initial oxygenation was 97% then dropping. Patient (R1) with pulse and spontaneous movements at that time. During transport, patient (R1) became less responsive, sats dropped below 50% despite supplemental oxygen and bag valve mask. Patient (R1) lost her pulse at that time. Past Medical History: Dysphagia Patient Active Problem List: Dysphagia; Esophageal Dysphagia PE (Physical Examination): General – unresponsive; HEENT (Head/Eyes/Ears/Nose, and Throat) – pupils fixed/dilated, no corneal blink reflex; Cor – no palpable pulse Patient (R1) expired during transport to hospital after choking episode with respiratory arrest. On 08/25/25 at 3:05 PM, V6 (CNA) was asked on R1's incident on 08/12/25. V6 replied, "She was in her room, sitting in bed. I gave the dinner tray. I offered to feed her, but she refused, she said she can do it. She is able to do it. She cuts her foods. I was there. Her dinner was turkey, and some little bit of pasta. I was supervising her, then she stopped eating, her hand was in her throat. So, I did Heimlich and while I am doing it, I called then nurse who was in front of her room. When I saw she (R1) was holding her throat and choking, I positioned myself behind her, while she (R1) was sitting on the bed, the bedside table in front of her, I placed my hand below the breasts and started pushing it upwards. When nurse (V9, Registered Nurse, RN) came, she (V9) took over, she (V9) went to bed and sit behind her (R1) and did the same thing. Everybody came and we continue to do the Heimlich. While we are doing it, we		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 5 called paramedics. The food couldn't come out despite Heimlich. There were tiny bit of foods coming out from the mouth. She was unable to respond verbally. We are still doing the Heimlich, we put oxygen, she was still not responding. Paramedics came; they took over. She was not responding but still breathing. The foods still did not come out. There was a small amount of saliva coming out from her mouth with small foods. When she was taken by the ambulance, she was breathing but not responding." On 08/26/25 at 12:21 PM, V9 was also asked regarding R1's choking episode on 08/12/25. V9 stated, "She had the choking incident on 08/12/25 afternoon shift. Trays were passed, V6, her CNA gave her the tray and asked her (R1) to assist with cutting foods, but she (R1) refused. V6 was standing there while she was eating when she noticed that she (R1) was holding her (R1) neck and choking. At the time, I was at the nurses' station and went there right away. I started to do Heimlich, she (R1) was sitting at the edge of the bed. I placed my both hands under rib cage and did abdominal thrusts. I told V6 to call out everybody. I asked other staff to continue the Heimlich, and I called emergency services. While others are doing the Heimlich or abdominal thrust, one of the staff, V14 (RN) said food came out and asked her (R1) if she feels better and she (R1) said yes. While we're doing Heimlich, we placed oxygen via nasal cannula to her (R1). Paramedics came. Nasal cannula was changed to nonrebreather mask. Her oxygen saturation was 60%, it was low. She was picked up by paramedics, she was alert, awake, breathing with nonrebreather mask. The cause of her choking was the food that she was eating. V6 tried to cut her food but she (R1) doesn't want any help. It was a hotdog in a bun. It was whole when it was served. She ate the hotdog in a bun." On 08/27/25 at 11:58 AM, V14 (RN) was asked regarding R1 and the incident on 08/12/25. V14 stated, "I was working on the other side when I hear from the page about rapid response, and I went there. I observed R1 sitting at the edge of the bed, not breathing because a staff was doing the abdominal thrust. Her eyes were open but unable to talk. When it was my turn, I did the Heimlich maneuver. She (R1) was still sitting, I was behind her (R1), I wrapped my arms around her (R1) waist, below sternum, and made an upward thrust. Food has not come out yet. I continued, I saw the food coming out from around her mouth and started to see it coming out. I swiped it out with my fingers. It was chunky with a little bit of slush. She started breathing again and said she can breathe. Her oxygen saturation was 97%. Approximately 5-10 minutes EMS		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 6 came. She is alert and can answer all my questions." On 08/28/25 at 4:21 PM, V22 (Ambulance Crew) was asked regarding R1's disposition on 08/12/25. V22 stated, "We were dispatched on 08/12/25 around 5:17 PM to a call from facility for choking. We went there, walked in. When I saw the resident (R1), she was lying in bed and had shallow respirations, had a suction and a nonrebreather mask. She had a cannula but not connected to oxygen. She had a nonrebreather mask on but not connected to any oxygen. She was not responsive to verbal and painful stimuli, we called out her name, there was nothing. There was no eye opening. But she had a heart rate under 100 and SpO2 under 60s, that's what I have seen in their monitor. When we put her (R1) to our monitor, the SpO2 was 60%. There was no facility staff in the room when we get there. So, I went back out of the room and everybody, which I am sure were staff working in the facility, were just standing around. I asked what's going on and they pointed to the lady on the phone. She must be nurse, and she told me that resident (R1) was eating, then choke, they did Heimlich, did suction, and she said, I quote "they were able to get a little bit." When we put the resident (R1) on the monitor, we asked them if there is a DNR. No one can tell me anything. So, at that point, our main concern was the patient (R1) so we move her (R1) to our cot." On 09/02/25 at 10:37 AM, V33 (RN) was also asked regarding R1's incident on 08/12/25. V33 verbalized, "I was at a different floor and heard the rapid response and I went to her room. I don't know the resident (R1). There were a lot of staff already in her room. She was with nasal cannula; connected to pulse oximeter. She was breathing abdominally with difficulty. I heard the nurse said she called 911. So, I went downstairs to hold the elevator for EMS. But they already went upstairs. When I went upstairs, she (R1) was already in the stretcher, and I asked the nurse to print the DNR (do not resuscitate) form and gave it to the police officer. Her (R1) eyes were open but not alert and oriented. I didn't really talk to her." V33 was asked regarding choking and on how to do the Heimlich maneuver. V33 stated, "I will ask resident and if a resident cannot talk and holding throat, I will do the Heimlich. With resident on the floor, I will go on top of the resident and I'm going to do the abdominal thrust. Place heel of the palm of hands at the bottom of the sternum and push upwards. If resident is standing, I will be behind resident, wrapped around my arms, with both hands pushing upwards. If resident is sitting, I will be behind the resident."		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 7 On 09/02/25 at 10:49 AM, V32 (CNA) was asked regarding R1's choking incident. V32 replied, "I was in the hallway and heard a call from V6. I went into the room. Her (R1) eye were wide-open, hands-on throat. We started the abdominal thrust. She was sitting at the edge of the bed. I was behind her. I put my right-hand underneath and left hand over it. Right where the end of the bone in the middle chest, moving upward and thrust. We did a finger sweep and a piece of bread and meat came out. The resident (R1) was sitting, responsive, we asked her, she was able to squeeze my finger when I asked her to. She (R1) was already alert. Paramedics came; she was alert when she left. I was in the room when paramedics came. I did not leave her (R1). I was there, V6 was there and all other staff, inside the room. My main concern at the time was the resident (R1) if she was okay." On 09/02/25 at 10:55 AM, V31 (CNA) also stated during interview, "On 08/12/25, I heard the page. I was in 1 West. I went to 2 East, to R1's room. The staff were already doing abdominal thrust. When I went there, she (R1) was already breathing. I didn't do any Heimlich. She was responsive. Paramedics came, I went out of the room, but nurses and other staff were still there in the room. We did not leave the patient (R1). When paramedics came, she (R1) was alert, verbally responsive. I heard her (R1) say "yes". I saw her oxygen saturation 97%. When I went there, she was breathing. I heard the nurse asked if she's okay, she said yes. Then I stepped out. I did not do the Heimlich." V31 was asked how to do Heimlich maneuver. V31 verbalized, "Doing Heimlich, place both hands between breast under the center bone, and make an upward thrust. We do the Heimlich until food comes out and resident is breathing." Facility stated in their incident report that R1 was alert, talking and breathing when picked up by EMS. V9, V14, V31 and V32 all stated R1 was alert, oriented and verbally responsive when paramedics came and transported to hospital. However, ambulance report indicated R1 was found unresponsive by EMS. On 08/25/25 at 3:50 PM, V8 (Director of Food Services) was asked regarding R1's dinner on 08/12/25. V8 stated, "On 08/12/25, menu was hotdog, and she was served with turkey hotdog. V19 did not want us to give him red meat. Per V19, no red meat and no pork per R1's preferences. She (R1) was served with foods, CNA offered to assist her, she refused, and she choked." A follow up interview with V6 was conducted on 08/26/25 at 3:25 PM regarding supervision while R1 eats. V6		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 8 verbalized, "I served her dinner, I let her cut the foods because she refused. I was standing by the table supervising her, looking at her while she eats. I didn't say anything or tell her to eat slowly or small pieces and bites. I just stood there and watched her, then she started coughing and holding her throat." On 08/27/25 at 11:12 AM, V11 (CNA) was interviewed regarding R1. V11 stated, "I have taken care of her in the past. She was admitted to our unit. She is alert, oriented to person and place; able to verbalize needs; supervision to limited assistance for ADLs (activities of daily living). With eating, she is on supervision. Supervision while eating means opening the milk, supervising if the patient is having hard time cutting foods. She eats by herself, more of supervising if she is eating the meal or if she wants the food. With R1, we don't need to tell her to eat slowly or tell her to cut her foods in small pieces. Because she is on general diet. Not that I know of that she is on aspiration precautions. On 08/27/25 at 11:32 AM, V12 (RN) was asked regarding R1 supervision when eating. V12 verbalized, "I took care of her when she was here in the facility. She is alert, oriented to person, place and time. She needs a lot of cuing, a lot of set-up, a lot of assistance. She has dysphagia. During eating, staff would observe her. She was on one-on-one supervision during eating. Staff is sitting next to her while eating, observe, cue her to eat slowly, small bites, chew and swallow. We would cut the foods for her. She was on a strict aspiration precaution, so we need to watch and cue her while eating." On 08/27/25 at 11:48AM, V13 (CNA) was also asked regarding R1. V13 mentioned, "She is alert, oriented, demanding. She needs help in performing ADLs because she is unsteady. During eating, she was on supervision and cue her to eat. Bring the tray, open the milk, juice and let her to sit on the edge of the bed or chair - I watch while she eats. We cue her that she needs to eat, she needs energy. She does not have any dysphagia, and she can eat whatever she wants to eat, that's what V19 said. She (R1) does not have a problem with swallowing." In a follow up interview conducted on 08/27/25 at 2:34 PM, V7 was asked on what interventions should be done for R1 related to aspiration precautions. V7 stated, "R1 is on full aspiration precautions. Staff has to remind her to eat slowly. With my clinical recommendations for R1, she needs to be sitting upright when eating; eat slowly; small sips and bite slowly;		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 9 clear the mouth when done with food; chew food well, don't get distracted, don't talk; if there is a need that she eats big chunk of food, make sure she cuts her foods in small pieces." R1's care plan documented: Compromised nutritional status (07/21/25): Interventions: Determine food preferences. Weigh the resident monthly as ordered. Allow ample time to complete the meal. Offer between meals snacks and meal substitutions as appropriate. Offer the resident a bedtime snack. R1's difficulty swallowing was not addressed in any care plan. There were no other care plans presented by facility related to her (R1) swallowing problems. On 08/27/25 at 3:22 PM, V8 (Director of Food Services) was asked regarding R1's care plan related to swallowing difficulties. V8 replied, "I initiated dietary care plan of R1, only for the menu choices. Other than that, I did not evaluate her for any swallowing difficulties. I am not aware that she has swallowing difficulties. I did not do her full dietary care plan, only the portion about food preferences. I do revise care plan only food preferences, likes and dislikes. If there is a significant change, I don't do revisions or updates. We follow speech therapist recommendation for consistency change, other than that no." On 08/28/25 at 2:08PM, V20 (Dietitian) was also asked regarding R1's care plan for swallowing difficulties. V20 stated, "I was the one who did her admission assessment and one more follow-up after I spoke with V19. I saw her (R1) and assessed her to check up on her. I don't do swallowing test. V7 put in a concern about swallowing difficulties but she (R1) refused the video test. V19 wants to put her on a general diet. For R1, I don't believe I did a care plan. I am not aware if she has difficulty swallowing. I was not notified of anything about her swallowing difficulties. That is why we did the care plan for meal preferences." On 08/27/25 at 3:35 PM, V2 (Director of Nursing) was asked regarding R1. V2 verbalized, "She has a history		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 10 of dysphagia which is reversible. She is on supervision or touching assistance during eating. Staff visually supervised her, cuing like if she needs anything. She doesn't need to be prompted. She can eat on her own. For R1, she needs supervision when eating and she was supervised. R1 exhibited that she can do everything, and staff had supervised her. When she had the choke, we were on top of that, she was alert and talking when transported to the hospital." On 08/27/25 at 4:58 PM, V21 (Medical Director) was interviewed regarding resident with swallowing difficulties. V21 stated, "For residents with dysphagia or difficulty swallowing, we have to follow whatever the speech therapy recommends. Go by what speech therapy suggest or recommends. Then talk to patient and family regarding recommendations and depending on what family wants. Nowadays, health of the patient is managed and directed by family. Look for specific instructions from speech therapy if resident is on aspiration precautions. Like for example, if it says small bites, they should be getting small bites. Follow the guidelines from ST and make sure staff follow instructions. And it should be care planned and needs to be in the interventions." On 08/28/25 at 4:21 PM, V22 (Ambulance Crew) also mentioned during interview, "When we moved her (R1) over to our cot, we noticed a bruise underneath the sternum, under breasts area. That is not the proper placement of the hands when doing Heimlich maneuver. It would not be effective. If resident is already unresponsive, they have to do CPR. When we got there, she (R1) was still in sitting position, almost laying down. So, when they were doing the Heimlich, she was in a sitting position. Then it is not effective. It should be in a standing position." The following staff were interviewed regarding Heimlich maneuver: Interviews with V6, V9, V14, V31, V32 and V33 all stated with them positioned behind resident, placing both hands below the sternum or rib cage and make an upward thrust. 08/26/25 at 11:11 AM: V23 (Licensed Practical Nurse, LPN) verbalized, "Go behind the resident with both hands on the lower sternum and in a scooping motion do the abdominal thrust. We do it while standing and we can do it while resident is sitting. We check the mouth if we're able to see if not suction it. If patient passes out, we call code blue. Continue abdominal		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE
S9999	Continued from page 11 thrust until food comes out." 08/26/25 at 11:20AM: V17 (CNA) mentioned, "Hand placed below the sternum; push up, resident can be sitting or standing up." 08/26/25 at 11:24AM: V24 (CNA) stated, "We call nurse right away, do CPR and start chest compressions." 08/26/25 at 11:29 AM: V25 (CNA) stated, "The resident needs to be in a sitting position. CNA behind the resident needs to be sitting as well. With locked hands, placed between breasts and pushed upwards and talk to resident to know if food went down or out. If not continue the thrust and get help." 08/27/25 at 11:12 AM: V11 stated, "During choking, swipe if there is any obstruction, then perform the Heimlich, ask for help. With resident sitting, placed one hand making a fist and other hand on top of the fist hand below the sternum and make an upward push. Do the Heimlich until food comes out." 08/26/25 at 11:33 AM: V16 (RN) stated, "When doing the Heimlich maneuver, if a resident can stand, we do it standing, if he can sit, we can do it sitting, but more on standing. Make a fist with one hand and placed below sternum and pull up. If he can't talk and nothing went out, we continue to do the Heimlich." 08/26/25 at 11:46AM: V27 (CNA) stated, "Lift the bed, call for help. Sit the resident up." 08/27/25 at 11:48AM: V13 stated, "Do the Heimlich maneuver with resident sitting, go behind the back and make fist and place it under the rib cage and make a push upwards until the food come out. I have to call for help." 08/26/25 at 12:00PM: V29 (CNA) stated, "Position resident leaning forward, tap the upper back 3 to 5 times. Call nurse or use call light." 08/26/25 at 12:05PM: V28 (LPN) stated, "Bring up the head and do the Heimlich maneuver. With fist hands placed below the sternum and move upward. Resident could be sitting or standing." In a follow-up interview conducted on 09/08/25 at 9:07AM, V21 was asked regarding staff training in dealing with emergency situations on a resident. V21 verbalized that there should be procedures and plans that should be followed in accordance with state and			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 12 federal guidelines. V21 also added, "These staff/nurses coming from other countries/places need to go to rigorous trainings and should follow procedures and plans for emergency situations." Facility's policy titled "Comprehensive Care Plan" dated 11-17-17 stated in part but not limited to the following: Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Facility's "Emergency Care for Choking", undated stated in part but not limited to the following: Conscious Victim: If victim can breathe, cough or make sounds, do not interfere. If victim cannot breathe, cough or make sounds, ask if you can help. Give quick upward thrusts above the belly button and below the ribs until object is forced out, victim can breathe again, or victim becomes unconscious. Unconscious Victim: Send someone to call 911 and get the Automated External Defibrillator (AED). If you are alone, perform 5 sets of 30 compressions and 2 breaths before leaving to call 911. Follow these steps: 1. Give 30 compressions pushing down at least 2 inches on the center of the chest. Place one hand on top of the other. Push hard. 2. Open the airway and check the mouth for objects. Remove the obstructing object only if you see it. 3. With the airway open, attempt to give two breaths. If unsuccessful, return to compressions. Repeat steps 1,2 and 3 until victim starts breathing or until emergency medical help arrives. Facility's policy titled "Cardiopulmonary Resuscitation – CPR" dated 3-22-22 documented in part but not limited to the following: Guidelines: This facility will provide basic life support,		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055558		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE NORTHBROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 270 SKOKIE HIGHWAY , NORTHBROOK, Illinois, 60062			
(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) COMPLETION DATE	
S9999	Continued from page 13 including CPR – Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives. CPR for Choking Event: In the event that a resident is observed choking, Heimlich Maneuver will be initiated and will continue until the airway obstruction is cleared or emergency personnel arrive. If the airway is cleared and the resident has no pulse or respirations, CPR will be initiated regardless of DNR status. Facility's Adult and Child Choking First Aide Guide, undated, documented in part but not limited to the following: Emergency Steps Ensure scene safety, assess, get consent, and wear PPE (personal protective equipment) as needed. Recognize choking signs immediately. Call 911 if there's any doubt or the person can't breathe or respond. Provide care: 5 back blows: Stand or kneel behind; use heel of hand between shoulder blades. If still obstructed, 5 abdominal thrusts: Thrust inward/upward above the navel. Alternate sets until the person can cough, cry, speak or becomes unresponsive. If the person becomes unresponsive, lay them flat and begin CPR, starting with chest compressions. After compressions and before giving breaths: open mouth, look for visible obstruction. Remove object only if easily visible, do not sweep blindly. (AA)		S9999				