STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE NORTH BRANCH	6840 WEST TOUHY AVENUE , NILES, Illinois, 60714

(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 Complaint Investigations 2599446/2631367 - no deficiency 2599577/2633127 - 300.690	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.690a) 300.690b) 300.690c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the	S9999		

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

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S9999	Continued from page 1 phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by: Based on interview and record review the facility failed to report an unusual death of a resident (R1) to the IDPH Regional office for one out of three residents reviewed for accidents and incidents in a total sample of four. Findings Include: R1 is a 49 year old with the flowing diagnosis: spinal stenosis, anxiety disorder, post-traumatic stress disorder, and polysubstance abuse. R1 no longer resides in the facility. A Nursing note dated 9/17/25 at 6:45PM documents R1 was found unresponsive at 5:51PM. CPR was initiated and 911 was called. Paramedics took over care when they arrived. Paramedics administered two rounds of epinephrine. Time of death was called at 6:10PM. Police remained on scene and call the medical examiner's office. Police arranged transport of the body to the medical examiner's office. A Nursing note dated 9/17/25 at 8:24PM documents the nurse gave narcotic pain medication at 7:15AM and scheduled benzodiazepine medication at about 9:45AM. The last time the nurse saw R1 walking the halls was around 2PM and 3:30PM. The CNA last saw R1 around 4PM. R1 was never in any acute distress during the shift. A Nursing note dated 9/17/25 at 9:16PM documents the funeral home picked up R1's body to bring to the medical examiner's office. On 11/16/ 25 at 2:22PM, V1 (DON) stated V1 and V6 (Administrator) didn't report the death of R1 because they didn't think it needed to be reported. V1 reported the facility didn't expect R1 to die because R1 had no major comorbidities and was younger. V1 stated V1 and V6 are responsible for reporting incidents to IDPH. V1 reported an accident, or incident is reported to IDPH	S9999		

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S9999	Continued from page 2 when it is an obvious injury or when there are inconsistencies in staff interviews. On 11/17/25 at 4:08PM, V6 (Administrator) stated nothing "out of the ordinary" occurred so the facility didn't report the incident IDPH. V6 reported the facility send reports to IDPH for injuries, "anything out of place," and abuse. V1 stated V1 and V6 are responsible for sending in reports to IDPH. V1 reported V6 was aware of R1 having pills by R1's bedside at the time of death but felt it still didn't warrant a report to IDPH. The surveyor requested a reportable incident investigation for the death of R1, and V1 reported no reportable incident was sent to IDPH. The Police Report that was sent by R1's family dated 9/17/25 documents the police arrived at the facility at approximately 5:53 PM. R1 was pronounced dead at 6:10 PM. The police officer first observed R1 lying on the bed. No signs of trauma or foul play were noted. The police officer looked around R1's room and two prescription bottles were found in R1's belongings. Both prescription bottles had R1's name on them. The prescription bottles were diclofenac sodium 75 mg filled on 7/24/25 and the other was an empty bottle of mirtazapine 15 mg filled on 7/5/25. The nurse reported it is not common for residents to keep prescription medication at their bedside. Nursing staff reported that staff don't normally search resident's belonging unless they have a probable cause to do so, so it is possible that R1 might've had the above prescription bottles hidden within R1's belongings prior to arriving at the facility. The Cook County Medical Examiner's office was notified at 7:17 PM. The primary care physician indicated that the death certificate would be signed once the medical examiner's office clears it. Both prescription bottles that were on scene were in inventory at the police department. The Death Certificate with no date documents a cause of death and manner of death as "pending investigation." The medical examiner is still investigating R1's death during this survey. The policy titled, "Incident and Accidents-Illinois," dated 4/7/19 documents, "Policy: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. Procedure: An 'incident' is defined as	S9999		

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S9999	Continued from page 3 any happening, not consistent with the routine operation of the facility, that does result in bodily or property damage. Physical or mental mistreatment (abuse-actual or suspected) of a resident is considered an 'incident' whether or not an actual injury occurred. An 'accident' is defined as any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for: 1. All serious accidents or incidents of residents. 2. All injuries of staff, families, visitors. 3. All unusual occurrences. 4. All situations requiring the emergency services of a hospital, the police, fire department, or coroner. 5. Any type of resident abuse. 6. All unexpected events that occur that cause actual or potential harm to a resident or employee…1. An incident/accident report is to be completed by a RN or LPN and is to include: a. Date and time of the incident/accident b. Full written statement and possible cause of the incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties…3. The Director of Nursing, Assistant Director of Nursing, or Nursing Supervisor must notify the following if an actual injury occurs: a. The Illinois Department of Public Health, by phone, within 24 hours of the occurrence. During normal working hours, the Regional Office must be called. On weekends and holidays, the Long Term Care Complaint Hotline phone number is to be used: i. A narrative summary of the incident is to be sent to the Illinois Department of Public Health within five working days. ii. Public health is to be notified of the following: (fire, suicide, unusual situations that would require intervention by the Illinois Department of Public Health or other government agencies (e.g., response to severe weather, evacuation of part or all of the facility, chemical spills, etc.…), incident, resulting in emergency services provided by the police, the fire department, the corner, etc.…, accidents, or medication errors, resulting in death or serious injury, requiring hospitalization, or any incident or accident which has, or is likely to have a significant effect on health, safety, or welfare of a resident or residents." (C)	S9999		