STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057760	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE PALOS HEIGHTS	12550 SOUTH RIDGELAND AVENUE , PALOS HEIGHTS, Illinois, 60463

(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 Survey: 2599110/262265, 2599093/2623166 & 2599163/2623942	S0000		10/01/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 care needs of the resident. These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to ensure staff obtained the resident permission prior to checking for incontinence, and inappropriately touched a resident in her vaginal area. This affected one of three residents reviewed for abuse. This failure	S9999		10/01/2025

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

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S9999	Continued from page 1 resulted under the reasonable person concept, in R1 expressing she felt angry, violated, she felt like V1 took something from her emotionally, she wanted to fight. Findings include: R1 BIMs completed on 9/15/25 denotes in-part R1 was able to report correct year, R1 was able to report correct day of the week, R1 was able to repeat three words after first attempt. R1 face sheet shows diagnosis of fracture of shaft of left femur, chronic congestive heart failure, type two diabetes, atrial fibrillation, chronic kidney disease, COPD, history of DVT, anxiety disorder, major depression disorder, obesity, and GERD. R1's police report dated 9/19/25, denotes in-part report number 2xxx-xxxxx, offense criminal sexual abuse, R1 briefly spoke about this incident, in summary: R1 woke up to a male black fondling her vagina along the outside of her diaper. R1 told him to stop and get out, to which the CNA left. R1 wished to proceed with this incident criminally. On 9/22/25 at 11:28am R1, interviewed at hospital, R1 observed alert to person, place, and time. R1 described V1 as the alleged perpetrator. R1 said on 9/19/25 she was sleeping and something told her to wake up, R1 said she observed V1(CNA) hand between her legs under her brief touching her vagina. R1 described it like V1 was massaging her brief, and V1 hand touched her vagina. R1 describes that her brief was loose in the area where it gathers between the legs. R1 said she grabbed V1's hand and pushed it away. R1 said she asked V1 what he was doing and V1 said he was looking for some chicken. R1 said she told V1 to get the Fxxx out of her room. R1 said V1 left the room. R1 said she called her friend and daughter. R1 said her daughter called the police. R1 said she did not want to work with V1. R1 said she did not inform the Nurse, the Director of Nursing, the supervisor or the Administrator, that she did not want to work with V1. R1 said she would hold her urine when she worked with V1 because she did not want to work with V1. R1 said she did not want to work with V1 after she thought V1 got upset with her because he had to change her twice when she had diarrhea episode. R1 said she felt angry, violated, she fell like V1 took something from her emotionally, she wanted to fight. On 9/21/25 at 10:08am V1 (CNA) said he upon start of his shift he completed rounds informing all residents that he was their aide, including R1 and R1's daughter. V1 said throughout the shift he was checking on R1 to	S9999		

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S9999	Continued from page 2 see if R1 needed anything. V1 said R1's daughter told him that R1 did not need anything every time. V1 said around 7:45pm he went to do rounds on R1. R1 was sleeping, he touched R1 lower leg to wake her. R1 woke up. V1 said he told R1 that I was there to make sure she is dry, R1 replied "I think I'm dry", V1 said he told R1 I would like to check to make sure she was dry. V1 said he patted R1's brief, R1 was dry. V1 said he always let the residents know what he is about to do. V1 said he asked R1 if she needed anything and to have a good night. V1 said he did not round on R1 anymore after that. V1 said he did not provide incontinent care to R1 that shift, V1 said he figured that R1 family provided incontinent care to R1. V1 said he didn't think it was odd that R1 did not urinate that shift because he worked with R1 in the past and R1 did not urinate. V1 omitted getting permission to check R1's brief for incontinent episode. V1 said R1 is alert and orient, R1 is incontinent and in the past R1 would put the call light on if she needed to be changed of bowel movement. V1 said he worked with R1 a few times in the past. 9/23/25 at 11:21am V9 (CNA) said when checking for incontinence and providing incontinence care, you should knock on the door, get permission to enter, announce yourself, inform the resident that you want to check and change their brief. V9 said if the resident is alert and orient, you should ensure to get permission before you touch them. If the resident refuses inform the nurse for guidance. V9 said if the resident is not alert and or has dementia, you should still announce yourself, inform the resident of the care you are planning to provide and keep them informed during the task. V9 said you check the brief by opening the Velcro, check the front, and also have the resident to turn to check the back because sometimes the resident brief looks dry in the front, and the brief is wet in the back. V9 said sometimes the brief is visibly soiled and you can see from the outside that it is wet. V9 said it is not the practice to pat/ massage or squeeze a brief. 9/22/25 at 9:51am V5 (Director of Nursing) stated that the facility practice is to check the resident for incontinence, sometimes residents are not alert and orient, staff should announce themselves, inform the resident of what they are about to do. V5 said if a resident is alert and orient staff should get permission before touching a resident. 9/22/25 at 3:35pm V11 (Social Service) stated she assessed R1's BIMS, V11 said R1 was alert and orient and forgetful of a few words during her assessment.	S9999		

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S9999	Continued from page 3 9/22/25 at 2:45pm V12 (Rehab Director) said R1 was dependent of staff for toileting, R1 needed one person assist with toileting, R1 could assist with turning. R1 care plan dated 9/16/25 denotes the resident denies having been exposed to trauma abuse/neglect prior to admission and denies having been the perpetrator of mistreatment, abuse, neglect, and/exploitation. The resident does not present with unusual risk in these areas at this time. The resident however does experience frailty/weakness. The resident will be treated with respect, dignity, and reside in the facility free of mistreatment (i.e., abuse/neglect) through the next review. Interventions are to conduct an Abuse/Trauma/Substance History assessment (as needed) to promote knowledge and understanding of residents past including social support system and coping mechanisms, and any history that may be useful towards the persons plan of care. Please encourage resident to maintain strong friendships and community involvement so that they are less likely to be isolated or lonely. Utilize person-centered care models that provide as much initiative, control, and self-determination as possible to address the persons physical, psychological, and social needs within a trusting, open, supportive and nonjudgmental professional relationship. R1 base line care plan dated 9/16/25 shows toileting not assessed. Facility policy titled Incontinence care with last revision date 4/20/2021, denotes in part to prevent excoriation and skin breakdown, discomfort and maintain dignity. Incontinent resident will be checked periodically in accordance with the assessed incontinent episode or appropriately every two hours and provided perineal and genital care after each episode. Explain the procedures to resident and bring equipment to bedside. Provide for privacy. perform hand hygiene and put on non sterile gloves. Facility policy abuse prevention and reporting effective date 11/28/2026 last revision date 10/24/22 denotes in-part; the 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 of property, and mistreatment of the residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy	S9999		

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S9999	Continued from page 4 is to assure that the facility is doing all that is within its control to prevent occurrence of abuse neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of the residents. 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. (B)	S9999		