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 11/25/2025

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 Facility Reported Incident of 10/26/25/2670289	S0000		12/04/2025
S9999	Final Observations Statement Of Licensure Violation: 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 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	S9999		

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

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 11/25/2025

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
S9999	Continued from page 1 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 and shall be practiced on a 24-hour, seven-day-a-week basis: 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 regulations were not met as evidenced by: Based on interview and record review, the facility failed to follow their fall prevention policy by not developing effective interventions for one high fall risk dementia resident who has wandering behaviors and requires supervision after a fall (9/7/25). This affected one of three residents R20 reviewed for falls prevention, this failure resulted in R20 sustaining another fall (10/26/25 forty-nine days later) with a head injury requiring transfer to the hospital and three sutures. Findings include:R20 was admitted to the facility on 8/15/23 with a diagnosis of dementia without behavioral disturbances, anemia, dysphagia, hemiplegia and hemiparesis affecting left side. R20's brief interview for mental status dated 10/1/25 score 6/15 which indicates severe cognitive impairment. R20's functional abilities under toileting dated 10/7/25 documents partial/moderate assistance; toilet transfers and walking 10 feet documents supervision or touching assistance. R20's morse fall scale evaluation dated 9/7/25 documents: R20 is high risk for falls. Under gait documents weak stooped but able to lift head without losing balance, steps are short, resident may shuffle. Under mental status documents overestimates or forgets limits.	S9999		

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 11/25/2025

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
S9999	Continued from page 2 R20's fall report on 9/7/25 at 5:30PM documents: R20 was observed sitting in her bed with blood on her shirt. R20 said she slipped and fell in her bathroom and hit her face on the toilet and was able to get herself up and back to her bed. Bruising and open area noted to mouth area. Resident was sent to local hospital and returned. Staff interviews indicate Resident was seen 30 minutes prior to the incident and assisted with care and bed in lowest position. Root cause analysis documents: Resident fall was due to resident ambulating without assistance, false sense of independence, impaired safety awareness impulsiveness. Interventions: R20 was sent to emergency room, therapy to screen and labs ordered. R20's hospital records after visit summary dated 9/7/25 documents under diagnosis head injury, contusion of lip, long term use of blood thinner, high blood pressure and slow heart rate. R20's therapy note dated 9/12/25 documents: Director of rehab (DOR) in to see patient after fall. R20 is a long-term care resident and is supervised by staff secondary to dementia and behaviors. R20 screened for therapy services and patients with noted cognitive deficits and poor safety awareness. No functional changes noted but continues to need supervision from staff secondary to cognition. R20 will not participate in therapy or restorative program. No therapy services indicated at this time and will encourage participation with restorative. R20's fall report dated 10/26/25 at 9:30AM documents: R20 was observed sitting on the floor in her room between the bathroom door and footboard of her bed with a laceration on her left eyebrow. Patient stated that she lost her balance and fell after using the bathroom, hitting her head on the footboard. Patient was sent to emergency room. V6(CNA) statement dated 10/26/25 documents: V6 last saw residents upon doing rounds at approximately 8:30PM. V6 said that R20 went to the bathroom at that time. V6 said during rounding she observed R20 on the floor and immediately made nurse aware. Interdisciplinary team note (IDT) documents: Resident was observed laying on the floor in her room between bathroom and bed. Nurse completed body assessment with open area to left eyebrow. Alert and oriented 1-2 able to make needs known with intermittent confusion. Medical doctor informed and aware to send to emergency room. Resident returned to the facility with three sutures to the left eyebrow. V6 stated that R20 was observed using bathroom at approximately 8:30pm and was	S9999		

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 11/25/2025

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
S9999	Continued from page 3 observed laying back on bed with bed in lowest position and call light within reach. Root cause analysis (RCA) documents: R20's fall was due to resident losing balance and falling. R20 is normally supervision with ambulation, generalized weakness. Interventions: IDT discussed for residents to have mediation review, psychiatrist evaluation and therapy to screen. Local hospital records after visit summary dated 10/26/25 documents: under visit seen for fall with diagnosis of head injury and open wound of face. Under instructions: suture removal in 5 days. Full hospital records requested but not available a time of survey. R20's progress note dated 10/27/25 documents: Resident returned to facility with three sutures to left eyebrow. Wound care will continue to monitor. R20's Wound note dated 11/10/25 documents: check left elbow sutures. Under exam documents three sutures noted over left eyebrow no signs of infection. On 11/25/25 at 10:02AM, V2(DON) was asked if the fall interventions put in place following R20's fall on 9/7/25 were effective. V2 said no but that they are monitoring R20. V2 was asked how often staff are monitoring R20 and she replied at least every 15-20minutes. V2 was asked how the staff are notified that R20 requires twenty-minute check and if it is documented. V2 said it is discussed at morning meeting and with nursing staff. Monitoring checks are not documented. There was no documentation of R20s monitoring in medical record or presented during the survey. V2 said R20 requires supervision with ambulating and has behaviors of wandering the unit. R20' s fall care plan documents revised date 2/21/25 documents: R20 is at risk for falls. Confusion, Deconditioning, Gait/balance problems, Incontinence, Poor communication/comprehension, Psychoactive drug use, Unaware of safety need. Interventions documented: 12/9/23 Assess patient for basic needs hunger, pain, toileting needs frequently. Date Initiated: 12/09/2023; 3/13/2024 Toilet before and after meals and at bedtime; Fall 3/12- Sent to ER for evaluation redirect behavior wandering. Date Initiated: 03/12/2024; Keep needed items, water, etc. in reach. Date Initiated: 08/16/2023; low Bed Date Initiated: 09/04/2025; Medication review Psych eval Therapy to screen r/t fall 10/26/25 Date Initiated: 10/26/2025; Sent to ER for evaluation Labs ordered Therapy to screen Date Initiated: 09/07/2025; Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated:	S9999		

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 11/25/2025

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
S9999	Continued from page 4 08/16/2023; Be sure call light is within reach and encourage resident to use it for assistance as needed. Date Initiated: 08/16/2023. Fall prevention Program policy revised 11/21/17 documents under purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Resident who requires assistance will not be left alone after being assisted to bathe, shower or toilet. Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is nonskid. In the event safety monitoring is initiated for 15- 20 minutes period, a documentation record will be used to validate observation. Comprehensive care plan policy revised 11/17/17 documents under 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 residents highest practicable physical, mental and psychosocial wellbeing. (B)	S9999		