STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145304	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Riverwoods	3705 Deerfield Road Riverwoods, IL 60015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure a resident was provided incontinence care in a safe manner for 1 of 3 residents (R1) reviewed for safety in the sample of 3. This failure resulted in R1 falling from the bed during care and sustaining bilateral toe fractures. The findings include: R1's Face Sheet shows that he admitted to the facility on [DATE] and has diagnoses of: morbid obesity, rheumatoid arthritis and history of falling. R1's Nursing Notes dated 4/21/25 at 2:20 PM shows that R1 is alert and oriented x 4, 2 assist with sit to stand and would be coming to facility after 2 PM. R1's Nursing Note dated 4/21/25 at 8:48 PM shows, Around 4:00 PM CNA (Certified Nursing Assistant) called this nurse and stated that the resident is on the floor .observed resident on the floor, laying a supine position, next to bed . On 4/30/25 at 9:22 AM, R1 was laying in bed. R1 had a bariatric bed. R1 had a splint to his right great toe. R1 had joint deformities to the fingers on his left hand. On 4/30/25 at 9:22 AM, R1 said that he had a fall out of bed and fractures his toes on both of his feet. R1 said that the aide came in to get him cleaned up and turned him to his right side. R1 said that once he turned, he was really close to the edge of the bed. R1 said that he was holding onto the side rail with his left hand. R1 said that due to his rheumatoid arthritis, he could no longer hold onto the railing so he let go and fell out of the bed. R1 said that he told the aide I am not going to be able to hang on much longer. R1 said that his top half fell off the bed first and he hit his head on the night stand and then his lower half fell and he hit his feet hard on the floor. R1 said that he was sent to the hospital and they told him that he had a fracture of his big toe on the right foot and two fractures on his left foot. R1 said that he returned to the facility and was unable to get out of bed until his orthopedic appointment that was 4/29/25. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/30/25 at 10:56 AM, V3, Certified Nursing Assistant (CNA) said that R1 had just admitted to the facility and the nurse practitioner told her that he needed to be changed so she went in to change him. V3 said that the nurse told her that he was a one assist so she was the only person in the room to provide the care. V3 said that R1 was in the center of the bed at the start of the care. R1 was turned to his right side by instructing him to grab the side rail with his left hand and she helped him turn his body to the side. V3 said that she was positioned on his left side of his bed. V3 said that when he turned, he was really close to the side of the bed due to him being so big. V3 said that at that time he had a standard size bed. V3 said that she could not move him closer to the center of the bed because of his size. V3 said that she started providing incontinence care and about 10 minutes into the care, he said that his hands were getting weak but before she could tell him to put his hand down, he fell off the bed. V3 said that his upper half flipped over the side rail and then his lower half went off the bed and he landed on the floor. V3 said that the incident happened around 3:45 PM on 4/21/25. On 4/30/25 at 10:12 AM, V6 (CNA) said that a resident should always be in the middle of the bed when providing care so they do not get too close to the edge of the bed and fall off. At 9:36 AM, V7 (CNA) said that residents should not be close to the edge of the bed when providing cares so they do not fall out of the bed. On 4/30/25 at 2:08 PM, V5 (Restorative Registered Nurse) said that during incontinence care, the resident should always be in the center of the bed. V5 said that the staff do not want them close to the edge of the bed to prevent them from falling. V5 said that if the resident is too close to the side of the bed once they are turned, the staff should use the pad or sheet that is under them to pull them closer to the middle of the bed before providing the cares. V5 said that staff should re-position them in bed prior to turning them so that when they are turned, they are still in the middle of the bed. On 4/30/25 at 1:24 PM, V4 (Therapy Director) said that R1 had not been seen by therapy yet prior to his fall due to him just arriving at the facility. V4 said that R1 was seen by Occupational Therapy on 4/23/25 and needed moderate assist of two staff to sit at the side of the bed. V4 said that Physical Therapy had to be postponed until after his orthopedic appointment on 4/29/25 due to him being non-weight bearing. V4 said that R1 should have had another person on the other side of the bed for safety especially since he was a new patient and they didn't know him too well and because of his size. V4 said that if the staff couldn't pull him back to the middle of the bed, they should have know to get a second person as well. R1's emergency room Note dated 4/21/25 shows, Your diagnosis: Right 1st phalanx fracture, left 5th metatarsal fx (fracture) R1's Nursing Notes dated 4/22/25 at 12:05 AM shows, returned from [Local ER] via ambulance stretcher . three person lift to bed. Post right 1st toe 2nd phalanx FX (fracture), left 5th metatarsal FX .noted with CAM boots on each foot. Per hospital, NWB (non-weight bearing) to feet until seen ortho in 1 week (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Orthopedic Office Visit Notes dated 4/29/25 shows, Patient presents the office today for evaluation of his right foot pain. Patient fell out of bed about 9 days ago. He struck his foot and suffered pain and swelling. Presented the emergency department where x-rays were taken revealing pt sustained a fracture of the right great toe, proximal phalanx and left small, fifth toe proximal phalanx and base of left fifth metatarsal. The facility's Fall Prevention Program Policy revised on 11/21/17 shows, The fall prevention program includes the following components: Use and implementation of professional standards of practice.