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	06/24/2026

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 - Minimal harm or potential for 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** Based on observation, interview and record review the facility failed to ensure residents were transferred in a safe manner and as directed by a physician for 2 of 4 residents (R1, R2) reviewed for resident safety and supervision in the sample of 4. The findings include:1.R1's admission care plan showed R1 was admitted to the facility on [DATE] for rehabilitation and aftercare after having all five toes amputated on his right foot due to his diagnoses of peripheral vascular disease, lower leg cellulitis, and diabetes. R1 was discharged from the facility on 6/17/26. R1's hospital admission report dated 6/4/26 showed R1 was non-weight bearing on his right foot due to the surgical wound on the foot from his toe amputations. R1's skin/wound note dated 6/5/26 showed R1's right foot surgical wound was closed with sutures intact to the wound. No bleeding was noted from the surgical wound.On 6/24/26 at 10:35 AM, a telephone interview was conducted with both V7 (Wife of R1) and V8 (Daughter of R1). V7 and V8 each stated, on 6/8/26, they witnessed R1 place his right foot on the floor and bear weight on his right foot, as facility staff transferred R1 into bed. V8 stated, shortly after R1 was transferred on 6/8/26, she noticed some bleeding on the gauze dressing surrounding R1's right foot surgical wound. V8 stated, I kept telling them (nursing staff) that (R1) was not supposed to bear weight on that foot at all but they kept moving (transferring) him. R1's skin/wound notes and nurses notes dated 6/8/26 showed V9 Wound Nurse observed a small amount of bright red bleeding from the surgical incision on R1's right foot. V7 (Wife of R1) and R1's nurse practitioner were notified of the bleeding. No new physician orders were noted.On 6/24/26 at 11:43 AM, V9 Wound Nurse stated R1 was admitted to the facility with an order for R1 to not bear any weight on his right foot. V9 stated, on 6/8/26, she observed a small amount of bleeding from R1's right foot surgical wound as she was changing the dressing to the foot. V9 stated V7 (Wife of R1) was present during R1's dressing change. V9 stated V7 stated the bleeding to the wound was caused by R1 bearing weight on his right foot earlier in the day during a transfer. V9 stated, I can't say what caused the bleeding. I wasn't there when he was transferred. It was a very small amount of bleeding. I did not see any open areas to the incision at that time. On 6/24/26 at 2:04 PM, V13 Certified Nursing Assistant (CNA) stated she and V12 CNA transferred R1 into bed on 6/8/26. V13 stated she knew R1 was not to bear weight on his right foot. V13 stated, (R1) kept putting his (right) foot down on the floor when we were trying to transfer him. We just continued to transfer him so we could get him into bed. On 6/24/26 at 12:35 PM, V3 Assistant Director of Nursing (ADON) stated, on 6/8/26, R1 was not supposed to bear weight on his right foot. V3 stated, If he was bearing weight on that foot during a transfer, the staff should have stopped the transfer and notified the nurse.2. R2's current care plan showed R2 was at risk for falls due to her diagnoses of weakness, dementia, and glaucoma. The plan showed R2 had sustained previous falls in the facility. R2 was cognitively impaired and exhibited impulsive behaviors due to her diagnosis of dementia. R2's restorative assessment dated [DATE] showed R2 required the assistance of one staff member, with the use of a gait belt, for all transfers. On 6/24/26 at 8:36 AM, V4 CNA placed a gait belt around R2's waist as R2 sat on the side of the bed. V4 transferred R2 into a wheelchair by lifting R2 up by placing her hands under R2's armpits. V4 did not use the gait belt to transfer R2. V4 wheeled (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 - Minimal harm or potential for actual harm Residents Affected - Few	R2 into the bathroom via wheelchair. V4 transferred R2 onto the toilet by holding onto the sides of R2's incontinence brief. V4 did not use the gait belt to transfer R2. At 8:41 AM, V4 CNA exited R2's room, leaving R2 alone and unsupervised on the toilet. On 6/24/26 at 12:45 PM, V10 Restorative Director stated staff are to hold onto the gait belt when transferring residents, not the arms or waist of the resident. V10 stated if a resident starts to fall during a transfer and staff are holding onto the resident, not the gait belt, this can cause injuries to the resident. V10 stated R2 is at risk for falls. V10 stated R2 should not be left alone while being toileted due to her history of impulsive behaviors and being at risk of falling if she tried to get up on her own. The facility's Manual Gait Belt and Mechanical Lifts policy dated 1/19/18 showed, Use of gait belt for all physical assist transfers is mandatory.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident's urinary catheter was kept off the floor and below the level of the resident's bladder for 3 of 3 residents (R1, R3, R4) reviewed for urinary catheters in the sample of 4.The findings include:1.R1's care plan dated 6/5/26 showed R1 was admitted to the facility on [DATE] with a urinary catheter in place due to his diagnosis of urinary retention. The plan showed R1 was discharged from the facility on 6/17/26. On 6/24/26 at 10:35 AM, a telephone interview was conducted with both V7 (Wife of R1) and V8 (Daughter of R1). V7 and V8 each stated R1's urinary catheter bag was on the floor while he was being transferred into bed by facility staff on 6/8/26. V7 and V8 each stated R1 was standing on the urinary bag as he was being transferred. On 6/24/25 at 1:11 PM V12 Certified Nursing Assistant (CNA) stated he and V13 CNA transferred R1 into bed on 6/8/26. V12 stated, I knew (R1) had a catheter, but I was standing behind (R1) when he was transferred so I don't know where his catheter bag was. On 6/24/26 at 2:04 PM, V13 stated she assisted V12 CNA with transferring R1 on 6/8/26. V13 stated, I honestly could not tell you where (R1's) catheter bag was when we transferred him. On 6/24/26 at 11:47 AM, V3 Assistant Director of Nursing (ADON) stated a resident's urinary catheter bags must be kept off the floor to prevent infection and cross-contamination. 2.R3's current care plan showed R3 had a urinary catheter in place due to his diagnoses of urinary retention and hydronephrosis. The plan showed R3 was diagnosed with a urinary tract infection (UTI) on 6/19/26. R3 was receiving IV (intravenous) antibiotics once a day, from 6/9-6/26/26, for treatment of his UTI. The plan showed, Position catheter bag and tubing below the level of the bladder.On 6/24/26 at 8:45 AM, R3 was lying in bed. His right knee bent at a 45-degree angle as his legs rested on the bed. An IV port was noted to his right arm. No urinary catheter bag hung off R3's bed. When R3 was asked if he had urinary catheter, R3 pulled up his right pant leg, pointed to his right thigh, and stated, It's right here. R3's urinary catheter bag was secured in place to his right thigh area. A backflow of urine, towards R3's penis, was noted in the catheter bag and tubing. When R3 was asked how long he'd had a leg bag in place versus a standard urinary catheter drainage bag, R3 stated, About a week. On 6/24/26 at 9:55 AM, R3 remained in bed with his urinary catheter bag attached to his right thigh. On 6/24/26 at 1:20 PM, V3 ADON stated a resident should only have a urinary catheter leg bag on when the resident is up and ambulating during the day. V3 stated, Residents that are in bed or are bed-bound should not have (urinary catheter) leg bags because urine cannot drain (out of the resident) into the bag. The bag needs to be positioned below the level of the resident's bladder to allow urine to drain. 3.R4's current care plan showed R4 had a urinary catheter in place due to his diagnosis of obstructive and reflux uropathy. On 6/24/26, this surveyor conducted a continuous observation of R4 from 9:29 AM-10:02 AM. At 9:29 AM, V5 CNA entered R4's room to provide cares to R4. R4's urinary catheter bag hung off the right side of R4's bed. The bag was secured to the bed frame. At 9:33 AM, V5 CNA lifted R4's catheter bag off R4's bed frame and laid the bag on R4's mattress, next to R4's leg. Upon placing the bag on the mattress, a back flow of urine was noted in R4's catheter tubing. R4's catheter bag remained on the bed until 9:53 AM. At 9:53 AM, the bag slowly fell off the right side of the bed. From 9:53 AM-10:00 AM, R4 remained in bed. R4's catheter bag hung loosely (not secured to the bed) during this time. At 10:00 AM, V5 CNA placed R4's catheter bag on R4's lap. V5 and V6 CNA transferred R4 from his bed to a chair via a mechanical lift. At 10:02 AM, V5 CNA lifted R4's catheter bag off R4's lap and hung it off R4's chair. On 6/24/26 at 11:47 AM, V3 ADON stated a resident's urinary catheter bag should never be laid on the bed of the resident or in the resident's lap as this positioning would not allow urine to drain into the bag. V3 stated urinary catheter bags are to be kept below the level of a resident's bladder to allow urinary drainage and prevent infection. The facility's Urinary Catheter Care policy dated 2/14/19 showed, Indwelling catheters may be secured to prevent (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma and tension. Catheters shall be positioned to maintain a downhill flow of urine to prevent back flow of urine into the bladder or tubing, during transfer, ambulation, and body positioning. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly.