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	08/06/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free of mental and verbal abuse for 1 of 27 residents (R56) reviewed for abuse in the sample of 27. The findings include:The facility's initial Serious Injury Incident report dated 8/4/25 showed, On 8/4/25, Administrator was made aware of an allegation of verbal/mental abuse. (R56) alleges that (V4 Certified Nursing Assistant/CNA) slammed her door and told her I'll show you what being mean looks like. MD (Medical Director) and Ombudsman notified. Final report to follow.R56's resident assessment dated [DATE] showed R56 was cognitively intact. On 8/4/25 at 9:50 AM, R56 stated that sometime over past couple of weeks she reported to a supervisor that she no longer wanted V4 CNA to take care of her because V4 CNA was mean to her. R56 stated V4 CNA would put me to bed late. She wouldn't answer my call light so I could get changed. R56 was unable to remember the supervisor's name that she spoke to about V4 CNA. R56 stated, Then this weekend, (V4 CNA) came into my room. She asked me why I reported she was mean. I told her to leave. She said I will show you how mean I am. She walked out and slammed my door. R56 stated, I don't like it when people speak to me like that. I have to live here the rest of my life. I don't want her to take care of me again. On 8/5/25 at 10:10 AM, R56 stated she reported this past weekend's incident, between her and V4 CNA, to V6 CNA on Saturday (8/2/25) or Sunday (8/3/25). On 8/5/25 at 10:30 AM, V6 CNA stated, on Sunday (8/3/25), R56 reported to V6 that V4 CNA had confronted R56 about reporting her for being mean. V6 CNA stated R56 reported V4 CNA had come into R56's room, said I will show you how mean I am, and then slammed her door. R4 CNA's timecard showed R4 worked in the facility on 7/31/25, 8/1/25, and 8/2/25.On 8/5/25 at 11:25 AM, V4 CNA stated last Thursday (7/31/25), she was told by V8 Facility Scheduler that she was no longer allowed to take care of R56 and was not allowed in her room because R56 reported that V4 CNA had been mean to her. V4 stated she went to R56's room to speak to R56 about reporting her, despite being told not to by V8 Facility Scheduler. V4 was unable to say exactly which day this happened, stating It was one of the evenings I worked on 7/31/25-8/2/25. V4 stated, I wanted to talk to her because she had said I was mean and I wasn't. I didn't want her to say or think I was mean. V4 denied slamming R56's door or making any threatening statements to R56 at that time. V4 CNA stated on Friday (8/1/25) or Saturday (8/2/25) R56's call light was on. V4 CNA stated she answered R56's call light. V4 stated, I went to her doorway to let her (R56) know that her CNA was busy. I asked her if she wanted me to come in and help her. (R56) said no and asked me to shut her door. I don't think I slammed her door, but I could have accidently shut it hard. V4 CNA denied making any threatening statements to R56 at that time. The facility's Abuse Prevention and Reporting policy dated 10/24/22 showed, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Mental abuse is the use of verbal or nonverbal conduct which causes or has to potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include but are not limited to: Harassing a resident. Yelling or hovering over a resident, with the intent to intimidate. Threatening residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure a stop date was included in the order for as needed psychotropic medications for 2 of 5 residents (R16, R51) reviewed for unnecessary medications in the sample of 27. The findings include: R16's Physician's Order Sheet dated 8/6/25 shows an order for Lorazepam (Antianxiety) 0.5 ML (1mg) every 24 hours as needed for anxiety and an order for Lorazepam 0. 5ml (1mg) every 4 hours as needed for anxiety, both started on 3/12/25.R51's Physician's Order Sheet dated 8/6/25 shows an order for Lorazepam 0.5mg every 4 hours as needed for anxiety started on 6/25/25.On 8/6/25 at 11:45AM V3 (RN, Assistant Director of Nursing) stated, Both (R16 and R51) are with hospice and sometimes they give a 14 day stop date and sometimes they don't. I try to audit the charts and catch them or the nursing staff can find it and change it. The facility policy entitled Psychotropic Medication- Gradual Dose Reduction 2/1/18 states, PRN (As needed) hypnotic, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale foe extended use and the expected duration for PRN use of the medication.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of abuse was immediately reported to administration for 1 of 27 residents (R56) reviewed for abuse in the sample of 27. The findings include:On 8/4/25 at 9:50 AM, R56 stated, This weekend, (V4 Certified Nursing Assistant/CNA) came into my room. She asked me why I reported she was mean. I told her to leave. She said I will show you how mean I am. She walked out and slammed my door. R56 stated, I don't like it when people speak to me like that. I have to live here the rest of my life. I don't want her to take care of me again. R56 was unable to verify if the incident with V4 CNA transpired on Friday (8/1/25) or Saturday (8/2/25). R56 stated she reported the incident with V4 CNA to V6 CNA on either Saturday (8/2/25) or Sunday (8/3/25). On 8/5/25 at 10:30 AM, V6 CNA stated, on Sunday (8/3/25), R56 reported to V6 that V4 CNA had confronted R56 about reporting her for being mean. V6 CNA stated R56 reported V4 CNA had come into R56's room, said I will show you how mean I am, and then slammed her door. V6 stated she reported the allegations to the weekend manager, V7 Infection Preventionist (IP), on 8/3/25. The facility's initial Serious Injury Incident report dated 8/4/25, at 2:53 PM, showed the facility's initial abuse investigation involving R56 and V4 CNA was not started until 24 hours after the allegation of abuse had been made. The report showed, On 8/4/25, Administrator was made aware of an allegation of verbal/mental abuse. (R56) alleges that (V4 Certified Nursing Assistant/CNA) slammed her door and told her I'll show you what being mean looks like. MD (Medical Director) and Ombudsman notified. Final report to follow.On 8/5/25 at 10:34 AM, V7 IP stated, on 8/3/25, V6 CNA reported to her that R56 reported V4 had been mean to her and R56 did not want V4 taking care of her anymore. V7 IP stated, (V6 CNA) did not tell me that allegedly (V4) had slammed (R56's) door and made the statement she would show her how mean she was. (V6 CNA) should have told me about that because that could be considered abuse. I would have reported that right away to (V1 Administrator) on that Sunday (8/3/25).On 8/5/25 at 10:50 AM, V1 Administrator stated an abuse investigation related to the incident between R56 and V4 CNA, was not initiated until 8/4/25 because V1 had not been informed of the allegations that V4 CNA slammed R56's door and then made the statement that V4 will show her how mean she is. V1 stated, I did speak with (V7 IP) over the weekend but she did not tell me about the incident because it sounds like (V6 CNA) didn't tell her. V1 Administrator stated V6 CNA should have called her directly on Sunday, 8/3/25, to report the incident and allegations involving R56 and V4 CNA because the allegations made by R56 could be considered verbal or mental abuse. V1 stated she has told her staff repeatedly that any allegations of abuse are to be reported to me, immediately. The facility's Abuse Prevention and Reporting policy dated 10/24/22 showed, This 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. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. This will be done by:. Implementing systems to promptly and aggressively investigate all reports and allegations of abuse. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review the facility failed to assist a resident to obtain medical appointments in a timely manner for 1 of 27 residents (R92) reviewed for quality of care in the sample of 27.The findings include: R92's face sheet shows he has diagnoses including: History of malignant neoplasm of the nasal cavities, ear and sinuses, and age related cataracts. On 8/5/25 at 9:23 AM, R92 said he is having a hard time getting his follow up appointments scheduled for his hip and for eye cataracts. R92 said its been several months and when he asks staff about getting the appointments they tell him, were working on it. On 8/5/25 at 1:53 PM, V2 (Director of Nursing) said the current process to schedule appointments is the nurses fill out a form or she V1 (Administrator) and V3 (Assistant Director of Nursing) audit the physician orders to find an order for an appointment. V2 found that a dermatology appointment is scheduled for R92 for December 2025 but there was no oncology appointment or appointment scheduled for cataract follow up. V2 verified with the surveyor that there are orders in R92's Electronic Medical Record (EMR) to see an Opthamologist at a local hospital for cataract follow up which was entered on 6/9/25 and for R92 to see an Oncologist for follow up for a suspicious bone lesion on his hip entered on 7/15/25. R92's Practitioner Progress notes completed by V11 (Nurse Practitioner) show on 5/13/25 V11 documented that R92 will need an oncology consultation for additional work up for a suspicious bone lesion on his right hip. R92 continues to document this in her progress notes on 5/20/25, 5/27/25, 6/3/25, 6/10/25, 6/17/25, 6/24/25, 7/1/25, 7/8/25, 7/15/25 and 7/22/25. V11's 6/10/25 progress note for R92 shows that R92 had an eye appointment on 6/9/25 and needs an appointment made for left eye cataracts at a local hospital or alternative provider. R92's EMR do not show any appointment was made for R92 to see the oncologist or for the cataract follow up. On 8/6/2025 at 10:10 AM, V1 (Administrator) said the had to let the staff person who had been scheduling medical appointments go and as a result V1, V2 and V3 are all catching things up and auditing the charts to check and schedule any missed appointments. On 8/6/25 at 10:38 AM, V11 said R92 has had a history of cancer and on a follow up CT scan they found a spot on R92's hip that is suspicious for metastasis and requires further workup by an Oncologist. R92 said she kept telling the former scheduler (V12) that he needed this appointment scheduled and V12 would just respond I am working on it. but the appointment was not getting scheduled. V11 said she was also communicating with the nurses about it and finally put in an order for it on 7/15/25. V11 said she after she alerted management that the appointment had not been scheduled she was contacted back that a biopsy maybe needed prior to the oncology appointment. V11 said she was also aware that R92 needed to have follow up for cataracts and she put that order in when she saw the consultation report on 6/9/25. V11 said R92 also told her has been waiting for appointments to get scheduled and was upset about it.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement low air loss mattresses at the correct settings for residents with pressure injuries. The facility failed to ensure a pressure prevention wheelchair cushion was in good and working order. These failures apply to 3 of 8 residents (R9, R126, R82) reviewed for pressure injuries in the sample of 27. The findings include: 1.R9's August 2025 wound assessments showed R9 had pressure injuries to his right heel, right lower leg, sacrum and mid-back area. The assessments showed all of R9's wounds were identified on 8/1/25, upon his readmission to the facility. R9's physician order dated 8/1/25 showed, Low Air Loss Mattress in use. Check for proper functioning and settings every shift. R9's weight record dated 7/8/25 showed R9 weighed 151.8 pounds (lbs). On 8/4/25 at 10:03 AM, R9 was in bed on a low air loss mattress. R9's low air loss mattress was inflated however the mattress settings showed the mattress was programmed for a resident weighing 250 lbs, not 151 lbs. On 8/4/25 at 12:45 PM, R9's low air loss mattress was still programmed for a resident weighing 250 lbs. 2. R126's August 2025 wound assessments showed R126 had pressure injuries to his left ischial tuberosity and sacrum. R126's physician order dated 7/4/25 showed, Low Air Loss Mattress in use. Check for proper functioning and settings every shift. R126's weight record dated 7/31/25 showed R126 weighed 148 lbs. On 8/4/25 at 12:43 PM, R126 was asleep in bed on a low air loss mattress. R126's mattress was inflated however the mattress settings showed the mattress was programmed for a resident weighing 320 lbs, not 148 lbs. On 8/5/25 at 8:12 AM, V9 Wound Nurse stated all residents in the facility are on low air loss mattresses. V9 stated, Those mattresses are weight based. The need to be set at an accurate weight of the resident to make sure the mattress is comfortable and so it fits the resident to make sure it's offloading areas of pressure on a resident's body. If the mattress is not set at the correct weight, it won't help prevent or heal pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's low air loss mattress operation manual (undated) showed the facility's low air loss mattress is designed for bed sore and wound care therapy treatment and prevention. The manual showed low air loss mattresses treat pressure injuries by continuously redistributing pressure across the body and reducing areas of pressure to wounds and bony prominences on the body. The manual showed staff were to turn the pressure adjust knob to the mattress to set a comfortable pressure level by using the weight scale as a guide. 3. On 8/4/24 at 10:30 AM R82 was sitting in his wheelchair in the dining room. R82's seat cushion appeared bottomed out and sunken in the middle and R82 was sitting directly on his sacral area. On 8/5/25 at 9:45AM R82 was in bed for wound care. R82 is very thin and R82's coccyx appeared boney and somewhat reddened. Zinc Ointment was applied for skin protection as ordered On 8/6/2025 at 9:23 AM R82 was attempting to stand and reposition himself several times in the wheelchair. R82's wheelchair cushion remains sunken in the middle and raised on the sides. (U shaped) R82's Wound assessment dated [DATE] shows that R82 is High Risk for Pressure Ulcers as of 8/3/25 and currently has Moisture Associated Skin Damage (MASD) to his bilateral buttocks. On 8/6/2025 at 11:23 AM V14 (RN Wound Care) stated, The cushion does look a little sunk in in the middle- I will see if we have another harder one in the office and try to switch it out. The facility policy Pressure Ulcer Prevention dated 1/15/18 states, Use pressure reducing pads in chairs (all types) to protect boney prominences for residents identified as Moderate/High/Severe risk.

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility failed to ensure 1 of 27 residents (R76) in the sample of 27 was evaluated by a dentist. This failure resulted in R76 developing a tooth infection and requiring antibiotic treatment.The findings include:On 8/4/25 at 10:04 AM, R76 said he has been waiting months to see the dentist. R76 said he has been telling the facility at his care plan meetings that he wants to see the dentist. R76 said he has been using Orajel (an over-the-counter numbing agent) for tooth pain and proceeded to take a tube of Orajel from a bag attached to his left side rail. R76 said he is now taking an antibiotic for his mouth infection and said his mouth is all swollen. R76's Physician's Orders (printed 8/5/25) show an order written on 5/8/25 at 11:13 AM which shows the following: Patient to be seen by a dentist per family request. Patient complains of sharpness on inside upper tooth, patient felt small piece of tooth break off. R76's Order Summary Report dated 8/5/25 show an order dated 7/30/25 for Clindamycin (antibiotic) three capsules every eight hours for Tooth Infection for seven days. On 8/5/25 at 1:52 PM, V2, Director of Nursing (DON), said a dentist comes into the facility to see residents once a month, and a hygienist comes once a month too. V2 said residents can get on the dental list by letting the nurse know they'd like to see the dentist, then the nurse notifies Social Services (SS). SS puts the patient on the dentist list to be seen. V2 said residents are generally seen the very next month, and the dentist will come sooner if there is an immediate need also. V2 said any of the residents can see the dentist. R76's Nurses Notes dated 5/8/25 at 11:17 AM show R76's family were visiting and requested R76 be seen by a dentist. Family reported that R76 complained of sharpness on his inside upper tooth after feeling a small piece of his tooth break off. An order for a referral to the dentist was placed and R76 was added to the inhouse dentist list. R76's Nurses Notes dated 7/30/25 at 10:27 AM show R76 is complaining of tooth discomfort and has swelling of the right cheek. R76's family would like R76 to be seen by the in-house dentist and was then added to the list. R76's Nurses Notes dated 7/30/25 at 10:55 AM show V16, R76's Nurse Practitioner (NP), ordered an antibiotic for R76 for his tooth. On 8/6/25 at 1:26 PM, V15, R76's doctor, said it's possible for a chipped tooth to turn into an infected tooth, but R76 should have had a dentist evaluate him. On 8/6/25 at 1:30 PM, V16 said she saw R76 yesterday (8/5/25) because they consulted her earlier in the week because they thought R76 had a tooth infection because he had swelling in the mouth and gums. V16 said she started R76 on antibiotics on 7/30/25, the day she was notified about R76's oral swelling. V16 said she also ordered to get him to a dentist ASAP. V16 said she was not aware of any prior oral concerns, pain, or a chipped tooth. V16 said having (oral) pain and a chipped tooth for a couple of months could have contributed to the development of a tooth infection. V16 said no oral problems regarding R76 were reported earlier; she was not aware of any prior oral/teeth complaints or concerns. The facility was unable to provide any documentation that R76 was seen by a dentist from 5/8/25 to 8/4/25. The facility's Policy on On-Site Health Care Services (undated) shows it is the facility's policy to assist residents in arranging health services on site as needed per resident request. On-Site services available include dental care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 27 residents (R153) reviewed for infection control in the sample of 27.The findings include:On 8/4/25 at 9:42 AM, R153 said he has wounds on his legs and feet. R153's room had no EBP signs on or near the entrance to his room and no Personal Protective Equipment (PPE) was located outside of his room. On 8/6/25 at 9:21 AM, V14, Wound Care Nurse, said R153 has an unstageable pressure ulcer on his right posterior ankle. V14 said R153 is getting daily wound treatment to the site. On 8/6/25 at 10:20 AM, V7, Infection Preventionist, said residents with open wounds need to be on EBP. The facility's Enhanced Barrier Precautions (EBP) Policy (effective 1/15/24) shows the purpose is to minimize the risk of acquiring, transmitting, or complications resulting from multi-drug resistant organism (MDRO) colonization among residents in this setting.