STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145662	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Niles	8333 West Golf Road Niles, IL 60714

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 interview and record review, the facility failed to provide adequate supervision and monitoring to prevent accidents for two of four residents (R183 and R129) reviewed for accidents. Findings include:R183 is a [AGE] year-old female who was admitted in the facility in 10/26/2021 with diagnoses of not limited to major depressive disorder, generalized anxiety disorder and bipolar disorder, and was discharged on 07/28/2025. R183 was R129's roommate. R129 is a [AGE] year-old female who was admitted in the facility with tracheostomy, and diagnoses of not limited to chronic respiratory failure and chronic obstructive pulmonary disease. R129 is on low air loss mattress and high humidity tracheostomy collar. On 11/19/2025 at 9:59AM during interview with R129, R129 stated that she cannot remember when the fire happened but can remember what happened. R129 stated that she was on bed and watching the television when she felt something hot on her right leg and saw something flickering on the right side of her bed by her bed. R129 stated that she immediately yelled out fire repeatedly to call for help. R129 stated that when it happened, her roommate, R183 got up and ran quickly out of the room. R129 stated that the nurse came in and tried to put out the fire. R129 stated that R129 had seen candles in a glass on R183's bedside table before the fire happened but had never seen it after the fire incident. On 11/19/2025 at 11:45AM during interview with V43 (Certified Nursing Assistant), V43 stated that she heard R129 yelling fire so she went to R129's room and saw the fire on R129's blanket. V43 stated that the nurse came in and took out R129's blanket off of her and put on the floor to take out the fire. V43 stated that they extinguished the left-over fire on R129's bed with a bucket of water from the shower room. On 11/20/2025 at 2:38PM during interview with V1 (Administrator), V1 stated that it was concluded during the investigation that R183 lit up a candle as the root cause of the investigation based on the other residents' statement that R183 admitted to them that R183 started the fire and how R183 described the candle that R183 lit up in detail. On 11/21/2025 at 9:21AM, V1 stated that residents are not allowed to have anything that poses a fire hazard in their rooms, including smoking materials and candles. On 11/21/2025 at 10:07AM during interview with V47 (Social Worker), V47 stated that if a resident is a smoker or expressed that they want to smoke, the resident is first assessed if they are safe to smoke. V47 stated that if the resident is deemed a safe smoker, they were allowed to keep all their smoking materials inside their room before the fire incident happened. V47 stated that R183 started smoking in September of 2024 was deemed a safe smoker at that time. On 11/21/2025 11:30AM during interview with V49 (Registered Nurse), V49 stated that she was at the nurse's station when she heard a resident scream fire. V49 stated that she immediately responded to the scream and saw the fire on R129's blanket. V49 stated that she took R129's blanket off and put out the fire, then she screamed for help. R129's Order Summary Report dated 11/21/2025 with active orders as of 05/06/2025 (prior to the fire incident) indicated R129 was on low air loss mattress and high humidity tracheostomy collar with order date of 03/22/2025. R183's admission Record indicated R183 was admitted in the facility in 10/26/2021 with diagnoses of not limited to major depressive disorder, generalized anxiety disorder and bipolar disorder, and was discharged on 07/28/2025. R183's signed facility admission contract on (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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(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	11/10/2021 did not indicate any personal property restrictions. R183's smoking contract signed 09/16/2024 did not indicate that smoking materials are not allowed in the rooms. Facility Report sent to Illinois Department of Public Health dated 05/09/2025 indicated that the new and final root cause of the fire was the candle that was lit up in the room by R183. Facility was unable to provide policy on Fire Prevention.