Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Elevate Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents (R1 and R2) who need assistance with ADLs (Activities of Daily Living) is given nail care, shaved facial hair and provided incontinence care in a timely manner. This failure affects two (R1 and R2) of three residents reviewed for ADL care program. Findings include:1.On 2/24/26 at 12:53PM V6 (Case Manager) said that V10 (Family member of R1) reported to her every time she visits R1, she always finds R1 soiled with urine and feces. R1 is incontinent of B&B (Bowel and Bladder) and unable to call for assistance due to her cognitive impairment cause by Alzheimer's. V10 also reported poor hygiene due to found feces on hands, face and hair. She reported V10's concerns to V3 (SSD-Social Service Director) but they missed calls and playing phone tag.On 2/24/26 at 9:30AM, Observed R1 lying on low air loss (LAL) mattress. R1 is awake, nonverbal and confused. She is calm and quiet. She does not have bilateral boots. V11 (LPN-Licensed Practical Nurse) said that R1 is nonverbal, confused and needs total care with ADLs and transfers. R1 is fed by CNAs (Certified Nursing Assistant) during meals. R1 does not have behavioral issues or refusal of care. V2 (ADON-Assistant Director of Nursing) and V11 (LPN) checked R1 for incontinence care. Observed disposable brief is soiled with urine. Observed sacral area (sacrococcygeal area) with superficial multiple clustered (4) superficial open wounds/excoriations and redness on entire sacral/buttocks area and dark discoloration extending to inner thigh. Observed bilateral heels with redness, dry with peeling skin and dark scab formation of right heel. V11 (LPN) said that she is not aware of R1's superficial open wound/ skin impairment. She did not receive report from the nurse during endorsement and from her CNA (V12) this morning. V11 LPN called V4 (Wound Care Coordinator). V2 (ADON) said that the CNA should notify the floor nurse or wound care coordinator for any changes in resident skin condition.On 2/24/26 at 9:50AM, V12 (CNA) said that she is the CNA assigned for R1. She has not provided morning care or incontinence care to R1, but she fed her this morning. R1 is confused, calm, quiet and no behavioral issues of refusal of care. V2 (ADON) said that the CNA should physically check resident for incontinence care every 2 hours. R1 was admitted on [DATE] with diagnosis listed in part but not limited to Pneumonia, Elevated WBC, Nondisplaced intertrochanteric fracture or right femur for closed fracture with routine healing, Contusion of right shoulder, Alzheimer's disease, Dementia, Type 2 Diabetes mellitus, Irritant contact dermatitis due to fecal, urinary or dual incontinence. Comprehensive care plan indicated: She has ADL self-care performance deficit. She has bladder and bowel incontinence. She is disoriented to place/time/person. Her memory is impaired. She has problems with decision making, insight, logic, calculation, reasoning, planning, organization, sequencing, social skills and or judgement. She has alteration in ability to communicate related to Spanish speaking.2.On 2/24/26 at 10:04AM, Observed R2's room door closed with posting COVID infection. V2 (ADON) said that R2 is on respiratory isolation for COVID. Observed no N95 mask or surgical mask, no face shield nor eye protection, no disinfectant/sanitizer on isolation cart. V2 took (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

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	02/25/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplies from the nursing station. At10:08am Surveyor, V2, and V14 (LPN) entered the isolation room. Observed no isolation waste bin inside the room. Observed R2 lying on LAL mattress with machine on the floor. She was still marked with ashes on her forehead. She said she received ash marking on her forehead last Wednesday (2/18/26). She said that they have not given her a bath or shower since then. She has facial hair and has oxygen via nasal cannula. Her breakfast tray is on the bedside tray table. R2 said that she only ate the sausages. She said that she was not provided morning care, and she is soiled. Observed bilateral nails long with black matter inside. R2 said that her nails need to be trimmed. She denied refusal of care. V2 said that the CNA is responsible for providing nail care and shaving facial hair. V2 said that the CNA has to physically check for incontinence care every 2 hours. V15 (CNA) said that she is not the CNA assigned to R2 but was requested to help them with incontinence care. She said she does not know who the assigned CNA for R2 is. V14 (LPN) and V15 (CNA) repositioned R2 to her right side. Observed R2 soiled with urine, the disposable brief and bed linen were soaked with urine. V14 and V15 provided incontinence care. On 2/24/26 at 1:16PM, Informed V11 (LPN) that V15 (CNA) said that she is not the assigned CNA for R2. No one provided morning care nor checked for incontinence care to R2 this morning not until the surveyor came. V11 said that she did the residents assignment, and that V15 (CNA) is the assigned CNA for R2. She said she will talk to V15.On 2/24/26 at 1:48PM, Informed both V1 (Administrator) and V2 (ADON) of above concerns. V2 (ADON) said that they don't have policy on nail care and facial care shaving for female residents. Both cares are incorporated in ADLs care. On 2/25/26 at 11:17AM, V19 (CNA) said that she is the regular CNA for R2 on 7-3 shift. She said that she always provided incontinence care after breakfast. She always starts her rounds for all her assigned residents after breakfast around 9am because she has to pass breakfast trays first. She does not check for incontinence first. She said that she did not provide morning care or a bed bath to R2, she just provides incontinence care and changes her gown and bed sheets.R2 was admitted on [DATE] with diagnosis listed in part but not limited to Cerebral palsy, COVID 19, Chronic obstructive pulmonary disease, Arthritis multiple sites, Idiopathic peripheral autonomic neuropathy. Comprehensive care plan indicated: She has ADL self-care performance deficit. She has bowel and bladder incontinence. R2's progress notes dated 2/19/26 to 2/23/26 indicated no refusal of care.Facility's policy on Incontinence care revision 1/16/18 indicated: Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or every two hours and provided perineal and genital care after each episode.Facility's policy on Activity of daily Living indicated: Grooming: Maintaining personal hygiene, including planning the task and gathering supplies combing and or styling hair, face and hands, brushing teeth, shaving or applying make-up, oral hygiene, self-manicure (safety awareness with nail care) and or application of deodorant or powder.Facility unable to provide policy on Nail care and facial shaving.Facility's policy on complete bed bath revised 1/31/18 indicated: Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Procedure: wet wash cloth and apply soap, if requested. Wash, rinse and pat dry face, neck, ears and behind ears.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Elevate Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 wound/skin care interventions to prevent deteriorating of MASD (Moisture Associated Skin Disorder), to resident (R1) who is at high risk for skin impairment. This failure affects one (R1) of three residents reviewed for Pressure Ulcer/Wound Care Management. Findings include:On 2/24/26 at 12:53PM V6 (Case Manager) said that V10 (Family member of R1) reported to her every time she visits R1, she always finds R1 soiled with urine and feces. R1 is incontinent of B&B (Bowel and Bladder) and unable to call for assistance due to her cognitive impairment caused by Alzheimer's. On 2/24/26 at 9:30AM, Observed R1 lying on low air loss (LAL) mattress. R1 is awake, nonverbal and confused. She is calm and quiet. She does not have bilateral boots. V11 (LPN-Licensed Practical Nurse) said that R1 is nonverbal, confused and needs total care with ADLs (Activities of Daily Living) and transfers. R1 is fed by CNAs (Certified Nursing Assistant) during meals. R1 does not have behavioral issues or refusal of care. V2 (ADON-Assistant Director of Nursing) and V11 (LPN) checked R1 for incontinence care. Observed disposable brief is soiled with urine. No sacral dressing. Observed sacral area (sacrococcygeal area) with superficial multiple clustered (4) superficial open wounds/excoriations and redness on entire sacral/buttocks area and dark discoloration extending to inner thigh. No barrier /treatment cream residue observed on sacral area. No bilateral heel dressing. Observed bilateral heels with redness, dry with peeling skin and dark scab formation on right heel. V11 (LPN) said that she is not aware of R1's superficial open wound/ skin impairment. She did not receive report from the nurse during endorsement or from her CNA (V12) this morning. V11 (LPN) called V4 (Wound Care Coordinator). V2 (ADON) said that CNA should notify the floor nurse or wound care coordinator for any changes in resident skin condition.On 2/24/26 at 9:47AM, V4 (WCC-Wound Care Coordinator) said that R1 has MASD. V4 said that R1's last assessment dated [DATE] indicated 100% redness on sacral area extending to buttocks/perineum/ thigh improved. He said that R1 has a healed right heel pressure ulcer dated 2/20/26. V4 said that he is not aware that R1 has superficial open wounds on sacral area and a dark scab on right heel. He said that R1 has MASD and it may have on and off denuded wound/excoriations. R1 received mycology cream for wound care. V4 said that he is not aware of these skin changes. He was not notified by CNA or floor nurse. V4 said that The CNA or the floor nurse should notify him if there are any changes in resident skin condition.On 2/24/26 at 9:50AM, V12 (CNA) said that she is the CNA assigned to R1. She has not provided morning care or incontinence care to R1, but she fed her this morning. R1 is confused, calm, quiet and no behavioral issues of refusal of care. V2 (ADON) said that the CNA should physically check resident for incontinence care every 2 hours. On 2/24/26 at 10:00AM, V4 (WCC) and V12 (WCN) provided wound care to R1. After cleaning with normal saline, measured clustered open wound/excoriated skin as 4cm (centimeters) x 4cm, applied mycology cream and covered with foam dressing to sacral area. V4 also applied mycology cream to reddened sacral area extending to dark discoloration on inner thigh. V4 applied bilateral foam dressing to bilateral heels. V4 said that R1 has bilateral heel foam dressing three times per week. Informed V4 that R1 was not observed with sacral dressing, heel dressing and bilateral boot protectors. V4 said that R1 usually refused heel boots and dressing. R1 was observed calm, quiet and receptive to treatment. No refusal nor agitation was observed during wound care. Surveyor requested wound report after wound care to both sacral and right heel. On 2/24/26 at 11:17AM V4 (WCC) presented copy of R1's wound report completed today. Informed V4 and V24 (Vice President of Clinical services) of picture taken today 2/24/26 was not clear/visible of the multiple/clustered superficial open wounds on sacral area. The way the picture was taken does not provide view of the sacral area as compared to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Elevate Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous pictures of wound report taken appropriately. V24 said that he will have V4 (WCC) take another picture for better visualization of the denuded/excoriated wound.On 2/24/26 at 1:08PM, V9 (LPN) said that she is the regular nurse for R1. She took care of R1 yesterday morning and evening shift (2/23/26). She is not aware that R1 has skin impairment/ open wound on sacral, but she knows that she is at high risk for skin impairment. She has not seen R1's sacra area. She said, the CNA assigned to R1 did not report any skin changes. The CNA should check resident for incontinence care at every 2 hours and report any changes to the nurse. On 2/24/26 at 1:48PM, Informed V1 (Administrator) and V2 (ADON) of above concerns.On 2/25/26 at 12:29PM, V23 (Care Plan Coordinator) said that they are expected to implement care plan interventions for wound care.On 2/25/26 at 2:23PM, Followed up with the updated wound picture of R1 to V2 (ADON). Facility unable to provide. R1 was admitted on [DATE] with diagnosis listed in part but not limited to Pneumonia, Elevated WBC (White Blood Cell), Nondisplaced intertrochanteric fracture or right femur for closed fracture with routine healing, Contusion of right shoulder, Alzheimer's disease, Dementia, Type 2 Diabetes mellitus, Irritant contact dermatitis due to fecal, urinary or dual incontinence. Active physician order sheet indicated: Wound care: sacrum extended to buttocks/perineum/thighs: clean with cleaning wipes or soap and water apply mycology cream daily and as needed for MASD. Wound care: sacrum/buttocks: cleanse with NS (Normal saline) apply foam dressing as needed every 24 hours as needed for protection. Wound care right and left heel: cleanse with NS apply ABD (dressing) and tubigrip or foam 3x/week MWF and as needed. Comprehensive care plan indicated: She has sacrum extended to buttocks/perineum/thighs extensive MASD. Interventions: Keep skin clean and dry. Monitor skin during care and report any changes. Offload heels using heel protecting devices. Ongoing assessment of wound to evaluate signs of deterioration or improvement. She has ADL self-care performance deficit. She has bladder and bowel incontinence. R1's care plan and progress notes does not indicate that R1 is noncompliance with bilateral heel protectors' boots/offloading with pillows.Most recent wound report indicated: 2/17/26 -Sacrum extending to buttocks/perineum. MASD incontinence. Date identified 1/10/26. No blanchable erythema 100%. Measures 0x0x0cm. Improved. 2/24/26 Sacrum extending to buttocks/perineum. MASD incontinence. Blanchable erythema 95%. Pale pink non-granulating 5%. Measures 4x4x0cm. Cluster as one superficial open wound to sacral area. 2/17/26- Right heel pressure ulcer. Date identified 1/10/26. 100% skin intact. Measures 0x0x0cm. 2/24/26- Right heel pressure ulcer. Dry scaly skin with scab formation. Blanchable redness.Facility's policy on Skin condition assessment and monitoring- Pressure and non- pressure revised 6/8/18 indicated: Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: *Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. *Care givers are responsible for promptly notifying the charge nurse of skin breakdown.*At the earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.Facility's policy on Pressure ulcer prevention revised 1/15/18 indicated: Purpose: To prevent and treat pressure sores/pressure injuryGuidelines: 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. May use lotion on dry skin.3. Change bed linen per schedule and whenever soiled with urine, feces or other material.11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated. 12. Moisture barrier may be applied by CNA as needed to intact skin and may be kept at bedside.Comprehensive care plan (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 11/17/17 indicated: Purpose: To develop a comprehensive care plan that directs the care plan team and incorporates the resident's goals, preferences and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Guidelines:The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.