STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interviews and record review, the facility failed to protect a resident's (R1) right to be free from physical abuse from an employee for one (R1) of four residents reviewed for abuse in a sample of four. This failure resulted in R1, who is severely cognitively impaired, being physically assaulted by an employee and experiencing pain. R1, as a reasonable person would not expect to be harmed in their own home or health care facility, causing them to feel fear, anxiety, and anger. Findings include: R1 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance; Other Seizures; Essential (Primary) Hypertension; Insomnia, Unspecified; Anxiety Disorder, Unspecified; and Mild Hyperemesis Gravidarum. According to R1's MDS (Minimum Data Set) assessment dated [DATE] under section C, R1 has BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. R1's memory impairment care plan dated 12/13/2024 reads in part, (R1) activity involvement is limited as a result of cognitive, memory impairment. (R1) leaves during activities, resists, refuses invitations to programs, spends her leisure time out in the common area watching television. Interventions: Involve (R1) in programming for cognitively impaired persons, as appropriate. Programs may include sensory awareness, sensory stimulation and/or sensory integration. Use resources and lesson plans emphasizing these techniques for reaching and connecting with this population. Absent are R1's communication barriers care plans prior to the incident on 03/23/2025. Absent are R1's dementia care plans prior to the incident on 03/23/2025. Absent are R1's abuse care plans prior to the incident on 03/23/2025. (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 - Actual harm Residents Affected - Few	On 03/24/2025 at 11:32 AM V5 (Anonymous Visitor) said, On 03/23/2025, I was visiting my relative in the facility. Around 8:12 PM, I went to the third-floor unit and that's when I saw (V8 Licensed Practical Nurse/LPN) punching (R1) twice. I asked if (R1) was ok, she responded (V8 LPN) hit her twice. Allegedly, (R1) grabbed (R2's) oxygen tubing as she was trying to get through and (V8 LPN) came up to (R1) and punched the right side of her upper back. There was no other staff present. It happened right by the nursing station. I reported it to V6 (Restorative Director/Manager on call) and they assured me that (V8 LPN) will be leaving with handcuffs on if not willingly, and that they will call the police. About an hour later, I followed up with the local police department, but they had no report of the incident. I also reported it to V1 (Administrator/Abuse Prevention Coordinator). On 03/24/2025 at 12:45 PM V6 (Restorative Director/On Call Manager) said, I got a phone call from V7 (Licensed Practical Nurse) stating that the V5 (Anonymous Visitor) came down and voiced some concerns and that she will let me speak to V5 over the phone. V5 said that she witnessed V8 (LPN) hit R1. V5 further said that she tried to pull out her phone to record a video, but she didn't do it quick enough and only recorded the after effect. I told V5 that I will call V1 (Administrator/Abuse Prevention Coordinator) and V2 (Director of Nursing). I immediately removed V8 (LPN) from the third-floor unit and drove over to the facility. The only discussion I had with V8 (LPN) was to gather his belongings, punch out and leave immediately. I came to the facility around 9:45 PM. I went to assess R1. R1 had no injuries, no bruising, no redness, no raised areas. I talked to R1 but her BIMS (Brief Interview of Mantal Status) is 3, so her response to my question was not appropriate. I asked if R1 was ok, she said, she was ok. R1's vital signs were stable. The only concern R1 had was pain in the right scapula, R1 rated it at 3. It was a new pain. I gave R1 pain medication. I checked on R1 again within 45 minutes and she was asleep. I notified on call nurse practitioner of the incident and received an order to continue pain management and monitoring. On 03/24/2025 at 1:11 PM Surveyor observed R1 sitting up in the bed in R1's room. R1 appears relaxed and calm. When asked if R1 was hit or pushed last night (03/23/2025), R1 said, I don't know. R1 denies any pain to the right side of her back at this time. On 03/24/2025 at 1:44 PM V1 (Administrator/Abuse Prevention Coordinator) said, I got a call from V6 (Restorative Director/On Call Manager) last night (3/23/2025) at around 8:30 PM. V6 said she was calling to report an allegation of abuse. I asked V6 what happened, V6 said V5 (Anonymous Visitor) said that V8 (Licensed Practical Nurse) punched R1 on the back. I made sure V8 (LPN) was removed from the duty and R1 was assessed and is doing ok. I told V6 I will be coming to the building shortly. I spoke to V8 (LPN) on the way to the facility. V8 (LPN) said that he was at the nursing station, R2 was on the left side of the common area and R1 was sitting on the couch behind R2, which was around the same area. V8 (LPN) had to redirect R1 from playing with R2's oxygen tubing several times. V8 (LPN) then got up with intention of moving R1. As he attempted to move R1, V8 (LPN) heard voice yelling: You hit her! You hit her! V5 (Anonymous Visitor) actually said that V8 (LPN) punched R1. V8 (LPN) denied the accusation. I got to the facility around 9:45 PM. V8 (LPN) was gone by then and I just followed our abuse protocol. I checked the schedule to see what other staff was working, I interviewed, the other nurse who was on the floor, spoke to all CNAs (Certified Nurse Assistants), and supervisor who called me. I interviewed R1, R1 was in bed at that time, R1 said she didn't remember of anything happened, denied being hit and said she is ok. I called V16 (Family Member), left her a voicemail saying what happened. I also notified the local police to report the allegation. The investigation is still ongoing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/24/2025 at 2:48 PM V7 (LPN) said, I worked last night (3/23/2025 between 3:00 PM -11:00 PM). At around 8:15 PM, V5 (Anonymous Visitor) came down and told me that (V8 LPN) struck (R1). V5 was trying to tell me that she didn't pull out her phone quick enough to record the incident but showed me the after effect recording of what happened. Surveyor asked what was V7's (LPN) impression of the incident recorded in the video, V7 (LPN) said, My impression of the video was that I had no words because V5 should have not been recording people without their consent. I recognized V8 (LPN) and R1 in the video. V8 (LPN) was denying hitting R1 upon V5's confrontation. V5 asked R1 and she confirmed she got hit twice. V8 (LPN) was then demonstrating what he did and R1 flinched a little when V8 (LPN) was swatting his hand by R1's right side. Surveyor asked if V8 (LPN) behaved appropriately in the video, V7 (LPN) said, I don't think what V8 (LPN) did was appropriate. After I watched the video, I called V6 (Restorative Director/On Call Manager) and told her what happened. V6 confirmed understanding, asked V5 to the phone and, right after that, told V8 (LPN) to leave the facility. On 3/24/2025 at 3:01 PM V2 (Director of Nursing) said, V5 (Anonymous Visitor) sent me a recording of the incident from last night (3/23/2024). When I saw the video, I thought it was intrusive to record residents in the facility. I notified V1 (Administrator/Abuse Prevention Coordinator) who was already aware of the incident and then I called V5 back and asked about what she sent me. V5 said, I saw (V8 LPN) hit (R1). On 3/24/2025 at 3:37 PM V10 (Certified Nurse Assistant) said, I worked on the third-floor unit on 3/23/2025 from 3:00 PM to 11:00 PM. I was at lunch break at the time of the incident, so I didn't see what happened. I remember, R1 and R2 were staying in the common area by the nursing for most of the afternoon and R1 was constantly playing with R2's oxygen tubing. I had to redirect it multiple times. On 3/24/2025 at 3:52 PM V8 (Licensed Practical Nurse) said, I worked on the third-floor unit on 3/23/2025 from 3:00 PM to 11:00 PM. R1 was not in my assignment but I cared for her multiple times in the past. After dinner, R2 was sitting in the wheelchair in the common area by the nursing station with his oxygen concentrator connected to the electric outlet in the wall. R1 came over to sit on the couch, right behind R2. R1 was attempting to pull the oxygen tube and disconnect oxygen concentrator from the electric outlet, so I redirected her. R1 did it a couple more times, so I finally came up to R1, and took the oxygen tubing away from R1. I leaned over R1, put my hand at her back and told R1 to leave the tubing alone. At the same time, V5 (Anonymous Visitor) started yelling. At first, I didn't realize she was yelling at me. V5 was yelling that I hit R1. I was trying to show V5 what happened, but I never hit R1, I had no reason to do it. V5 pushed R1 to say I hit her. After that, V5 left the unit, and shortly after, I received a call from V6 and was told to leave the facility. I gave my statement over the phone. I never got frustrated with R1, R1 is confused, I understand that. V8's (LPN) description of the incident shows that the physical contact V8 (LPN) made with R1 at the time of the incident (03/23/2025 8:12 PM) was unwarranted and punitive due to circumstances described by V8 (LPN). On 03/25/2025 at 12:39 PM Surveyor reviewed facility recording of the third-floor common area with time stamp of 3/23/2025 8:12 PM. Surveyor observed V8 (LPN) sitting at the nursing station, picking his head up and talking towards the area where R1 was sitting. R2 visible in the video as well. V8 (LPN) proceeds then to walk quickly walk over towards R1. Camera picture cuts off the area where alleged incident occurred. Surveyor unable to observe the alleged incident on the presented recording. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 at 12:46 PM V19 (Family Nurse Practitioner) said, I cannot tell you what happened at the time of alleged incident, I wasn't in the facility. I came in yesterday (3/24/2025) before lunch time, V2 (Director of Nursing) made me aware of the video, I didn't see it the video though. I assessed R1, R1 was stable, she was not aware of what is going on. R1 was not in pain yesterday. R1 does not have any chronic pain and is able to express acute pain. I wasn't made aware that she had pain in the right scapula post the incident nor that she received pain medication for the post incident pain. On 3/25/2025 at 1:18 PM In the follow up interview, V1 (Administrator/Abuse Prevention Coordinator) said, When V8 (LPN) first saw R1 getting 'busy' that day (3/23/2025), V8 should have gotten an activity staff involved. R1 could have been occupied with activity board or folding towels, something to get R1 engaged. Also, when R1 was sitting in the same area with R2, V8 (LPN) could have moved R1 sooner seeing her fixation with the oxygen tubing. V8 (LPN) should have given R1 other things to get occupied with to have to redirect her less. You find residents where they are, if you know that this is a behavior that she's having, V8 (LPN) should have thought what I need to do to decrease R1's fixation on that tubing or cord. Maybe V8 (LPN) could have reached out to the facility to encourage family to visit. When confronted by V5 (Anonymous Visitor), V8 (LPN) should have notified the supervisor right away instead of engaging with V5. On 3/25/2025 at 1:52 PM V16 (R1's Family Member) said, I met with V1 (Administrator/Abuse Prevention Coordinator) yesterday (3/24/2025) and requested to see facility's video that was recorded in the facility. I'm not comfortable with what happened. I understand there was an individual who recorded R1 and that makes me uncomfortable. Also, something must have happened that made the individual to start recording, something must have triggered them to do it. R1 said in the recording that's floating in social media that the nurse hit her twice. I am concerned with R1's safety until I find out what happened. When I saw the recording, V8 (LPN) appeared agitated, not sure if it was because he was getting recorded or because he just hit R1. Facility Reported incident dated 03/23/2025 reads in part, On Sunday, March 23, 2025, at approximately 8:45 PM (V5 Anonymous Visitor), alleged that (V8 Licensed Practical Nurse) struck (R1). V5 reported the allegation to (V6 Restorative Director/On Call Manager). V6 reported to (V1 Administrator/Abuse Prevention Coordinator). (V8 LPN) was immediately removed from the facility. (R1) was assessed with no signs of physical injury. Investigation initiated. (R1) safe in the facility. Police notified. Family and physician notified. Police report requested on 03/25/2025, unable to obtain it during course of the survey. V6's progress note dated 03/23/2025 11:14 PM reads in part, Writer performed a skin assessment on (R1) no areas of concern noted No bruising, redness, noted. (R1) stated she had pain to right scapula. ROM within normal limits. (R1) medicated for pain by assigned nurse. Writer made on call N/P (Nurse Practitioner) aware of incident stated to continue PRN (as needed) pain medication as needed and to continue to monitor. R1's Comprehensive Pain Observation (New) dated 03/23/2025 10:00 PM reads in part, Reason for evaluation: New report of pain; Information obtained from: resident; Presence of Pain: Does the resident exhibit signs or symptoms of pain, verbalizes the presence of pain, or requests interventions for pain? Yes; Pain Level: 3. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's March 2025 Medication Administration Record shows pain medication administered on 03/23/2025 at 10:01 PM for pain on level 3. The facility Abuse Prevention and Reporting - Illinois policy last revised on 10/24/2022, reads in part, 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. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. 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 and mistreatment of residents. This will be done by: Orienting an training employees on how to deal with stress and difficult situations, and how to recognize and report of abuse, neglect, exploitation, and misappropriation of property; Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.