

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/22/2024
NAME OF PROVIDER OR SUPPLIER Elevate Care Palos Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 12550 South Ridgeland Avenue Palos Heights, IL 60463	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570</p> <p>Based on interview and record review, the facility failed to prevent one resident (R1) from mental abuse caused by a staff member and failed to ensure the staff member had limited access to R1. This failure applied to one (R1) of three residents reviewed for abuse and resulted in R1 feeling on guard, untrusting and unsafe while living in the facility.</p> <p>Findings include:</p> <p>R1 is a [AGE] year old female who admitted to the facility 2/16/24. R1 has diagnoses that include Conversion disorder (functional neurological system disorder) and Generalized Anxiety Disorder for which she is receiving treatment in the facility. R1 is cognitively intact and uses a wheelchair for mobility according to the minimum data assessment dated [DATE].</p> <p>On 8/21/24 at 8:34PM, R1 was observed resting in bed, alert and coherent. R1 was interviewed and expressed an incident with a staff member (V3) that occurred a few weeks ago. R1 said that one evening, she went to the kitchen because she was hungry and asked V3 Dietary Aid for some food. V3 refused to give any food or snacks and called R1 a beggar. R1 said that she believed V3 was upset with her because she offered V3 soda pops from her personal refrigerator, but later stopped.</p> <p>R1 said, when she was refused food and V3 called her a name, she reported it to V1 administrator and V4 Dietary Manager via a letter. After the letter was received, the administrator had a meeting with R1, R1's family member and V4 Dietary Manager to discuss the incident. The end result led to V3's termination. R1 continued and said that about three weeks later, V1 came to R1's room insisting that R1 give V3 another chance because V3 was remorseful, and she should forgive V3 as [R1 is] a good Christian woman. R1 began crying as she continued. R1 said V1 then brought V3 into her room to make V3 apologize to R1, however he just said a general apology, not anything that he did wrong. V1 rehired V3 to be a CNA (Certified Nursing Assistant). R1 said, I was okay thinking that I wouldn't see V3 much because V3 was working in the kitchen, but now as a CNA, I see V3 all over and V3 even comes in my room to drop off the meals and take the tray. R1 said I feel so guarded around V3 because I don't trust V3. There have even been times that V3 has backed me up into a wall away from the cameras where no one could see and say ugly things to me. R1 continued to cry and said I thought I did all the things right by reporting and I don't feel safe and secure when V3 is around. I am also concerned if what he is doing to me, he can be doing to others that can't defend themselves.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145779
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/21/24 at 1:10pm V4 Dietary Manager said they received a letter from R1 that said that while working as a dietary aid, V3 was coming to her room drinking her personal drinks and watching television. V4 said 'there is no reason for any dietary aid to be going into a resident's room. When R1 told V3 she didn't want him to come into her room anymore V3 refused R1 snacks such as cereal and sandwiches. These things are allowed to be given when the kitchen is open by any kitchen staff.' After V4 received the letter, Guest Services Manager, the Administrator and V4 had a meeting with R1 and R1's family member. After the meeting, V4 said that V1 Administrator initiated an investigation into the issue and V3 was let go by Human Resources a day or two after. V4 found out V3 was terminated when V4 was told to remove V3 from the schedule.</p> <p>On 9/21/24 at 1:23pm V5 Human Resources Director said that V5 was aware of an incident with R1 who stated that V3 called her a beggar. I spoke with V1, who followed up with V3 and I was told to terminate V3 for discourteous behavior which is based off the handbook and facility policies.</p> <p>Employee Disciplinary Report reviewed for V3 dates the incident 9/2/24 with facts: Employee displayed improper conduct and discourteous behavior with patient which has resulted in termination. The report was dated 9/5/24 by V5.</p> <p>V3 was interviewed via phone on 9/19/24 and 9/21/24. During both interviews, V3 was evasive, omissive and unprofessional. During the interview on 9/19/24 at 10:16pm V3 said that V3 was irritated about being questioned by this Surveyor. When V3 was asked about any incident that occurred involving R1 and V3, V3 said he was told about it by an unknown staff member, and that there was no allegation brought against him. V3 also said that he had never been suspended or terminated.</p> <p>On 9/21/24 at 4:05pm, V3 said that there was a day that R1 came to the kitchen to ask for food, but the staff were about to leave and V3 told R1 the kitchen was closed. V3 said R1 always come to the kitchen asking for food, and V3 didn't give her any when she asked. V3 said V1 investigated an allegation against him but V3 didn't take the accusation seriously. Then V3 said I got fired for some b*****t. V3 said V1 Administrator asked V3 to come back as a CNA and was asked to apologize to R1. V3 said, he went to R1's room with V1 but said, I didn't apologize, I just said I'm sorry.</p> <p>On 9/21/24 at 2:45pm V1 Administrator said V1 was unaware that R1 was emotionally upset that V3 became a CNA and is giving direct care in the facility because V1 believed that after V3 issued an apology, R1 had forgiven V3. V1 said V3 should not be going into R1's room or giving care to R1, however it's possible that R1 would see V3 working elsewhere in the facility.</p> <p>Concern form dated 9/2/24 taken by V1 Administrator stated, Resident stated a dietary aide went into her room and took a beverage. Corrective actions taken: Writer interview the dietary aide (V3) Dietary aide stated he removed the dietary tray after mealtime. Offer to replace beverage declined.</p> <p>Abuse Prevention and Reporting policy revised 4/22 states in part; The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.</p> <p>(continued on next page)</p>

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F 0600 Level of Harm - Actual harm Residents Affected - Few	It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The abuse policy was acknowledged and electronically signed by V3 on 8/27/24 at 4:10PM.		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570</p> <p>Based on interview and record review, the facility failed to protect a resident from misappropriation of resident property. This failure applied to one (R1) of three residents reviewed for misappropriation of property.</p> <p>Findings include:</p> <p>R1 is a [AGE] year old female who admitted to the facility 2/16/24. R1 has diagnoses that include Conversion disorder (functional neurological system disorder) and Generalized Anxiety Disorder for which she is receiving treatment in the facility. R1 is cognitively intact and uses a wheelchair for mobility according to the minimum data assessment dated [DATE].</p> <p>On 8/21/24 at 8:34PM, R1 was observed resting in bed, alert and coherent. R1 was interviewed and expressed an incident with a staff member (V3) that occurred a few weeks ago. R1 said at one time, she was friendly with V3 Dietary Aid and offered some of her own personal soda from her refrigerator. R1 said she began to get uncomfortable when V3 would come into her room while she was napping and asked V3 to stop coming to the room. At the time, R1 didn't have a roommate, and then she got a roommate, R1 told V3 he couldn't come into the room anymore out of respect for the roommate.</p> <p>On 9/21/24 at 2:45pm V1 Administrator said, R1 informed them of a concern that V3 was taking and drinking her drinks.</p> <p>Concern form dated 9/2/24 taken by V1 Administrator stated, Resident stated a dietary aide went into her room and took a beverage. Corrective actions taken: Writer interview the dietary aide (V3) Dietary aide stated he removed the dietary tray after mealtime. Offer to replace beverage declined.</p> <p>According to V3's personnel file, V3 was terminated 9/5/24, related to this incident.</p> <p>Employee Disciplinary Report reviewed for V3 dates the incident 9/2/24 with facts: Employee displayed improper conduct and discourteous behavior with patient which has resulted in termination. The report was dated 9/5/24 by V5.</p> <p>Abuse Prevention and Reporting policy revised 4/22 states in part; The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>The abuse policy was acknowledged and electronically signed by V3 on 8/27/24 at 4:10PM</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570</p> <p>Based on interview and record review, the facility failed to report an allegation of misappropriation of property for a resident and failed to timely report an allegation of physical abuse for one resident to the Illinois Department of Public Health (IDPH). These failures applied to two (R1, R3) of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>R1 is a [AGE] year old female who admitted to the facility 2/16/24. R1 has diagnoses that include Conversion disorder (functional neurological system disorder) and Generalized Anxiety Disorder for which she is receiving treatment in the facility. R1 is cognitively intact and uses a wheelchair for mobility according to the minimum data assessment dated [DATE].</p> <p>Concern form dated 9/2/24 taken by V1 Administrator stated, Resident stated a dietary aide went into her room and took a beverage. Corrective actions taken: Writer interview the dietary aide (V3) Dietary aide stated he removed the dietary tray after mealtime. Offer to replace beverage declined.</p> <p>On 9/19/24 at 10:49pm, V1 Administrator said (V1) did not report the incident with R1 to Illinois Department of Public Health because (V1) didn't recognize the allegation as misappropriation of resident property.</p> <p>An initial investigation was reported to IDPH the following day on 9/20/24.</p> <p>R3 is a [AGE] year old female who admitted to the facility 6/18/24 with diagnoses that include multiple fractures and autism. On 9/20/24 at 3:56pm V3 was observed in bed alert and coherent. V3 called their representative and POA (Power of Attorney) on speaker phone during this interview. V8 (R3's Family member) said sent an email regarding concerns that R3 shared about V6 CNA (Certified Nursing Assistant) roughly providing care. V8 also notified nursing staff but was unable to recall who (V8) spoke to.</p> <p>V1 Administrator provided the email confirming that V8 communicated the allegation on 9/14/24. On 9/19/24 at 10:49pm, V1 Administrator said (V1) did not report the incident to IDPH until 9/16/24, because (V1) didn't check the email over the weekend.</p> <p>According to V8's time sheets, V6 was on duty and provided care 9/14/24 and 9/15/24 after V8 reported the allegation to V1.</p> <p>Abuse Prevention and Reporting policy revised 4/22 states in part; The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>All resident, visitors, volunteers, family members or other are encouraged to report their concerns or suspected incidents of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property to the administrator or an immediate supervisor who must then immediately report it to the administrator or the person acting as administrator in the administrator's absence. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated.</p> <p>Reports should be documented, and a record kept of the documentation.</p> <p>Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44570</p> <p>Based on interview and record review, the facility failed to provide evidence that an allegation of misappropriation of property was thoroughly investigated for a resident. This failure applied to one (R1) of three residents reviewed for misappropriation of property.</p> <p>Findings include:</p> <p>On 9/21/24 at 2:45pm V1 Administrator said, R1 informed (V1) of a concern that V3 Dietary Aid was taking and drinking R1's personal drinks. V1 said (V1) did not ask any other residents or staff about this allegation and V1 was unable to provide any written documents related to a related investigation.</p> <p>Concern form dated 9/2/24 taken by V1 Administrator stated, Resident stated a dietary aide went into her room and took a beverage. Corrective actions taken: Writer interview the dietary aide (V3) Dietary aide stated he removed the dietary tray after mealtime. Offer to replace beverage declined.</p> <p>Abuse Policy revised 4/22 states in part; Investigation Procedures: Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.</p> <p>Confidentiality: .Even if the facility investigation is not complete, the administrator will cooperate with any Department of Public Health investigation in the matter.</p>		