

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  09/23/2025
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)
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.  (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure staff obtained the resident permission prior to checking for incontinence, and inappropriately touched a resident in her vaginal area. This affected one of three residents reviewed for abuse. This failure resulted under the reasonable person concept, in R1 expressing she felt angry, violated, she felt like V1 took something from her emotionally, she wanted to fight. R1 BIMs completed on 9/15/25 denotes in-part R1 was able to report correct year, R1 was able to report correct day of the week, R1 was able to repeat three words after first attempt. R1 face sheet shows diagnosis of fracture of shaft of left femur, chronic congestive heart failure, type two diabetes, atrial fibrillation, chronic kidney disease, COPD, history of DVT, anxiety disorder, major depression disorder, obesity, and GERD. R1's police report dated 9/19/25, denotes in-part report number 2xxx-xxxx, offense criminal sexual abuse, R1 briefly spoke about this incident, in summary: R1 woke up to a male black fondling her vagina along the outside of her diaper. R1 told him to stop and get out, to which the CNA left. R1 wished to proceed with this incident criminally. On 9/22/25 at 11:28am R1, interviewed at hospital, R1 observed alert to person, place, and time. R1 described V1 as the alleged perpetrator. R1 said on 9/19/25 she was sleeping and something told her to wake up, R1 said she observed V1(CNA) hand between her legs under her brief touching her vagina. R1 described it like V1 was massaging her brief, and V1 hand touched her vagina. R1 describes that her brief was loose in the area where it gathers between the legs. R1 said she grabbed V1's hand and pushed it away. R1 said she asked V1 what he was doing and V1 said he was looking for some chicken. R1 said she told V1 to get the Fxxx out of her room. R1 said V1 left the room. R1 said she called her friend and daughter. R1 said her daughter called the police. R1 said she did not want to work with V1. R1 said she did not inform the Nurse, the Director of Nursing, the supervisor or the Administrator, that she did not want to work with V1. R1 said she would hold her urine when she worked with V1 because she did not want to work with V1. R1 said she did not want to work with V1 after she thought V1 got upset with her because he had to change her twice when she had diarrhea episode. R1 said she felt angry, violated, she fell like V1 took something from her emotionally, she wanted to fight. On 9/21/25 at 10:08am V1 (CNA) said he upon start of his shift he completed rounds informing all residents that he was their aide, including R1 and R1's daughter. V1 said throughout the shift he was checking on R1 to see if R1 needed anything. V1 said R1's daughter told him that R1 did not need anything every time. V1 said around 7:45pm he went to do rounds on R1. R1 was sleeping, he touched R1 lower leg to wake her. R1 woke up. V1 said he told R1 that I was there to make sure she is dry, R1 replied I think I'm dry, V1 said he told R1 I would like to check to make sure she was dry. V1 said he patted R1's brief, R1 was dry. V1 said he always let the residents know what he is about to do. V1 said he asked R1 if she needed anything and to have a good night. V1 said he did not round on R1 anymore after that. V1 said he did not provide incontinent care to R1 that shift, V1 said he figured that R1 family provided incontinent care to R1. V1 said he didn't think it was odd that R1 did not urinate that shift because he worked with R1 in the past and R1 did not urinate. V1 omitted getting permission to check R1's brief for incontinent episode. V1 said R1 is alert and orient, R1 is incontinent and in the past R1 would put the call light on if she needed to be changed of bowel movement. V1 said he worked with R1 a few times in the past. 9/23/25 at 11:21am V9 (CNA) said when checking for incontinence and providing incontinence care, you should knock on the door, get permission to enter, announce yourself, inform the resident that you want to check and change their brief. V9 said if the resident is alert and orient, you should ensure to get permission before you touch them. If the resident refuses inform the nurse for guidance. V9 said if the resident is not alert and or has dementia, you should still announce yourself, inform the resident of the care you are planning to provide and keep them informed during the task. V9 said you check the brief by opening the Velcro, check the front, and also have the resident to turn to check the back because sometimes the resident brief looks dry in the front, and the brief is wet in the back. V9 said sometimes the brief is visibly soiled and you can see from the outside that it is wet. V9 said it is not the practice to pat/ massage or squeeze a brief. 9/22/25 at 9:51am V5 (Director of Nursing) stated that the facility practice is to check the resident for incontinence, sometimes residents are not alert and orient, staff should announce themselves, inform the resident of what they are about to do. V5 said if a resident is alert and orient staff should get permission before touching a resident. 9/22/25 at 3:35pm V11 (Social Service) stated she assessed R1's BIMS, V11 said R1 was alert and orient and forgetful of a few words during her assessment. 9/22/25 at 2:45pm V12 (Rehab Director) said R1 was dependent of staff for toileting. R1</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>Based on interview and record review the facility failed to follow their policy to report an allegation of abuse within two hours of receiving an allegation for one of three resident (R1) reviewed for abuse reporting. Findings include: 9/21/25 at 2:25pm V2 (LPN) stated that R1 and R1 family alleged abuse by staff on 9/19/25 around 10:30pm. V2 said the administrator was made aware that night.9/22/25 1:55pm V4 (VP of Operations) stated the administrator did not report the allegation of abuse to the state department with 2 hours of receiving the allegation. V4 said an allegation of abuse should be reported within two hours of receiving the allegation. 9/22/25 at V5 (Director of Nursing) stated she reported an allegation of sexual abuse on 9/20/25.Review of the reportable submitted to the state department, report date is 9/20/25 at 1:43pm for sexual abuse.Facility policy abuse prevention and reporting effective date 11/28/2026 last revision date 10/24/22 denotes in-part; Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means abuse is the willful infliction of injury unreasonable confinement intimidation or punishment with resulting physical harm pain or mental anguish to a resident. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the department of public health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. Internal reporting requirements and identification of allegation: any allegation of abuse or any incident that results in serious bodily injury will be reported to the department of public heath immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.</p>		