STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145779	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Palos Heights	12550 South Ridgeland Avenue Palos Heights, IL 60463

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and Record review the facility failed to develop individualized ADLs (Activity of Daily Living) plan of care for Eight of Eight residents (R5, R6, R7, R8, R9, R10, R13, and R15) and failed to educate residents and family on anticoagulant medication for two residents (R8 and R9) in the sample reviewed for ADLs. This failure affected R5, R6, R7, R8, R9, R10, R13, and R15 who were dependent on staff for ADLs assistance and had the potential to affect all 98 residents residing in the facility.Findings include: R5's admission Record documents that R5 admission date as 05/26/2020 with listed diagnosis that includes but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, and muscle weakness (generalized) R5's MDS (Minimum Data Set) dated May 19, 2026, showed that R5 has a BIMS score of 13 indicating that R5 is cognitively intact. R6's admission Record documents R6's admission date as 05/06/2026 with listed diagnosis that includes but not limited to Hypokalemia, long term use of anticoagulants, and weakness. R6 MDS (Minimum Data Set) dated May 13, 2026, showed that R6 has a BIMS score of 14 indicating that R6 is cognitively intact. R7's admission Record documents that R7 admission date as 12/26/2024 with listed diagnosis that includes but not limited to anxiety disorder, pain left knee, long-term use of antithrombotic/antiplatelets, and type 2 diabetics mellitus without complications. R7 MDS (Minimum Data Set) dated May 20, 2026, showed that R7 has a BIMS score of 11 indicating that R11 is cognitively intact. R8 medical record admission record showed that R8 was admitted to the facility on [DATE] with diagnosis that includes but not limited to heart failure, anxiety disorder, Type 2 diabetes mellitus with diabetic chronic kidney disease and chronic kidney disease stage 3 unspecified. Long-term use of anticoagulants. R8 MDS (Minimum Data Set) showed that R8 has a BIMS score of 14 indicating that R8 is cognitively intact. R9 medical record admission record documents that R9 was admitted to the facility on [DATE] with diagnosis that includes but not limited to Chronic obstructive pulmonary disease unspecified, mental (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder not elsewhere specified, adult-onset fluency disorder, long-term use of anticoagulants, history of falling, restlessness and agitation. R9 MDS (Minimum Data Set) dated May 6, 2026, showed that R9 has a BIMS score of 14 indicating that R9 is cognitively intact. R10's admission Record documents that R10 admission date as 09/12/2023 with listed diagnosis that includes but not limited to Long-term use of anticoagulants, blindness one eye unspecified eye, gout, presence of pacemaker, dependence of cardiac pacemaker, and weakness. R10 MDS (Minimum Data Set) dated February 2, 2026, showed that R10 has a BIMS score of 06 indicating that R10 is cognitively impaired. During this investigation R9's medical record did not show any recorded education for R9 and family members. Reviews of R5, R6, R7, R8, R9, and R10 plan of care did not show any individualized interventions for ADLs (Activity of Daily Living) personal hygiene that includes shaving task. On 05/27/2026 at 9:30am, V2 DON (Director of Nurse's) stated that the care plan should be done following the Section GG of each resident according to their needs. V2 stated the way she knows it is to individualize the care plan for each resident. The cooperation program is what we follow, and they said since shaving is generalized care personal hygiene is what is rendered to all residents daily, so only mobility is focused. During this interview R5, R6, R7, R8, R9, and R10 were reviewed with V2 and was asked about ADLs care plan issue regarding care plan not individualized. V2 acknowledged that care plan should have interventions individualized, stating that it should be individual. On 5/27/2026 at 11:02 AM, V22 (MDS/Care Plan Coordinator / Licensed Practical Nurse) stated they changed her role to case manager and now she coordinates MDS and care plans. You have the care area assessments in MDS. V22 goes through the diagnoses first and looks at anticoagulants, psychotropics, things like that. The restorative nurse does the ADL care plans. She will formulate her assessment. V22 just coordinates. For the MDS sections, A is demographics. That is entered by the business office. Sections B, C, D, and E are done by social services. V22 does the care plans for the antidepressants and diagnoses, and she does the pain assessment in J, as well as surgery. Section F is completed by Activities. Sections GG and H are completed by Restorative. Section K is done by me. V22 looks at the dietary notes and the speech therapist notes. Section L is completed by me. Section M is done by wound care. V22 puts in what they entered in PCC. Medications are done by me. The top 1/2 of section O is done by me, the bottom 1/2 of section O is done by Restorative. Section P is restraints. We don't have any restraints in the facility. V22 does section Q. Social services do the discharge section. Activities of Daily Living (ADLs) are completed by restorative. For care plans, we meet. Restorative and therapy meet for ADLs. Restorative enters that care planning. V22 stated for R9 she thinks that the care plan for ADLs would be revised by Restorative. Restorative, Social Services and Nursing go to the care plan meeting. V22 does not attend it. They enter the care plan. V22 does not enter the care plan. On 5/27/2026 at 11:25 AM V23 (Restorative Director/Licensed Practical Nurse) stated, I complete the ADL fall and restorative care plans and update them as needed and quarterly. I assess residents for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs, I see how much assistance they need, if they need with bathing or if they need any specialty equipment. I am familiar with R9. V23 reviewed R9's care plan. I did not revise it on 5/26/2026. It was not me. If there is a care plan focus, there should be interventions to address the areas of focus and intended outcome. For R9, there are no interventions for the shaving area of focus. That is R9's preference. V23 stated every ADL care plan that she does, V23 addresses the specific needs for each resident. R9 prefers that his sister shave him. V23 stated she don't know who entered that. There are no interventions for that focus. There should be a way to see who went in and add that. V23 would have to ask corporate. R5, R6, R7, R8, R9, and R10 were shown to V23. V23 stated that the ADL care plan that the company uses is this care plan. Grooming is standard of care; they don't have just a care plan for grooming. If a resident has a deficit in one or multiple areas, it should be carefully planned and it should have interventions. This is the care plan that the company has taught us to use. The care plan should be personalized. We personalize mobility, but we don't personalize grooming. It is what the company uses. It should be adjusted for each resident. I mentioned something when they implemented the new care plans. They said that this is what they use companywide. It was brought up to corporate and we were told that this is what the company uses and what we were told to use. When a new employee starts, we have a restorative book. It is updated weekly – it talks about how they are transferred, personal hygiene. The restorative book should mirror the care plan – it is a quality-of-care issue. We also put information in the care profile for each resident. New employees need to look at both the Restorative book and the care plan to get an entire view of what the residents need as far as care. On 5/27/2026 at 11:53 AM V23 (Restorative Director/Licensed Practical Nurse) presented Patient Information Worksheet. V23 stated this is not part of the resident's record. We updated the Patient Information Worksheet This should be included in the care plan, but it isn't included. They updated the care plan process about a year ago. For at least a year, when they updated the care plan process, this information was missing from the care plan. I see the surveyor's concern. Usually when we update a care plan, the CMI meeting is restorative, Administrator therapy, social services, nursing. We discuss new residents, any changes, any reported concerns. The care plan is then updated as needed. In this facility, we must update both the care plan and then Patient Information Sheet, so the staff has correct information. R13 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following past medical history: acute on chronic systolic (congestive) heart failure, pleural effusion not elsewhere classified, acute kidney failure, hypertensive heart and chronic kidney disease with heart failure, dependence on supplemental oxygen, peripheral vascular disease, hypothyroidism, long term (current) use of anticoagulant etc. On 5/26/2026 at 11:58AM, R13 was in his room, awake and alert, stated he is doing okay, has been at the facility for about 2 weeks. R13 was observed with lots of bruising and discoloration on both arms and legs, R13 said that he bruises easily and takes blood thinner. Care plan initiated 5/1/2026 documented that R13 is receiving anticoagulant therapy, Eliquis related to Atrial fibrillation. Interventions include but are not limited to administer medication as ordered, monitor for signs and symptoms of anticoagulant complications, avoid use of aspirin or Nonsteroidal anti-inflammatory drugs (NSAIDs). Active physician order for R13 shows the following: Aspirin oral tablet delayed release 81mg, give 1 tablet by mouth one time a day for heart health. Eliquis oral tablet 2.5mg (Apixaban) give 1 tablet by mouth every twelve hours for blood thinner. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication administration record (MAR) for the month of May 2026 shows that R13 is taking both medications. On 5/27/2026 at 3:15PM, Surveyor presented this observation to V2 (DON) and V22 (LPN case manager) and they said that resident's care plan should be in accordance with physician order, they are not sure why the resident's care plan did not match with the physician order, for resident to have such care plan, the order must have come from the physician. They will investigate it and correct the problem. On 5/27/2026 at 3:02PM V24 (medical Director) was asked if R13 should be taking aspirin when his care clearly stated for resident to avoid aspirin and he said, it depends on the case, aspirin can be given for heart health, sometimes it is contraindicated, no one called him about resident's aspirin. Surveyor asked V24 if it's okay for R13 to be on Aspirin though his care plan stated to avoid it. V24 said, yes, R13 is on a low dose of Eliquis and low dose of aspirin, he is not sure why the care plan was initiated. On 5/27/2026 at 3:45PM, V22 said that she is the one in charge of the anticoagulant care plan, R13 was not on Aspirin when he originally came to the facility, he returned from the hospital with the medication, V22 said she should have revised the care plan to match resident's orders, she will take care of it now. R15 is 78 years admitted on [DATE], past medical history includes, but not limited to fracture of one rib, right side, subsequent encounter for fracture with routine healing, repeated falls, chronic respiratory failure with hypoxia, hyperlipidemia, anxiety disorder, long term (current) use of antithrombotic/antiplatelet, long term (current) use of aspirin, etc. Active physician order and MAR for R15 show that he is currently taking Aspirin 81 mg, one tablet a day for heart health, Plavix oral tablet, 75mg 1tablet one time a day for coronary artery disease (CAD). Review of baseline and comprehensive care plan for R15 does not show any care plan for resident's antithrombotic/antiplatelet medications. On 5/27/2026 at 3:15PM, V22 (LPN case manager) said that R15 is on antiplatelet so he should have a care plan for that, R15 was just admitted , V22 has not completed his care plan. V22 was asked if R15 has any antiplatelet care plan in his baseline care plan and she said no. Facility Comprehensive Care Plan presented with revision date 11/17/17 documented that the purpose of the policy is to develop a comprehensive care plan that directs the care 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. Facility policy titled Morning Care (A.M. Care) documents that the purpose of the policy is to promote comfort, cleanliness and dignity. Facility policy titled shaving Male & female Residents documented that the purpose of the policy is to provide cleanliness, comfort, and improve morale. Listed procedure include but not limited to male residents will be assessed for daily shaving need and assisted as his functional needs indicate. The policy documents that this policy is a guideline only, each resident has his or her own set of circumstances which may require that this policy is not followed, the needs of each resident supersede this policy (confirming ADLs individualized care plan).