STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care North Branch	6840 West Touhy Avenue 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their Fall Prevention Program policy. The facility failed to prevent fall incident and failed to follow the care plan intervention for fall prevention for residents assessed to be moderate and high risk for fall. This deficient practice affects two residents (R1 and R2) of three residents reviewed for fall incidents.Findings Include: 1. R1 is a [AGE] year-old male resident admitted into the facility on 7/17/2025. R1 is with diagnoses of but not limited to: Chronic Osteomyelitis right ankle and foot, Absence of the Right Foot, Type 2 diabetes, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 5 chronic Kidney Disease, Congestive Heart Failure, Dependence on Renal Dialysis, Cerebral Vascular disease, Anemia and Abnormal Posture. BIMS (Brief Interview for Mental Status) score of 15 (Cognitively Intact).R1 had multiple fall incidents in the facility, dated 7/30/25 and 8/1/25 both in the dialysis unit.R1 with MORSE Fall Scale Evaluation (Fall Risk Assessment) dated 7/17/25 as Moderate Risk, score of 31; post fall incident MORSE Fall Scale Evaluation score of 65 as High Risk, dated 7/30/25. Fall incident report dated 7/30/25, reads in part: Informed by dialysis nurse, R1 fell on the floor towards the end of dialysis treatment, did not hit his head, no injuries, vital signs within normal limits. Resident description: I told the staff I was having cramps on my legs and I really needed to move. They were unable to assist me right away and I had to get up. I lost my balance and fell on the floor. Fall incident report dated 8/1/25, reads in part: Informed by dialysis nurse R1 fell on the floor, hit his head and busted his lip while trying to get up towards the end of his dialysis treatment. Resident description: I told the staff I was having cramps on my legs and I really needed to move. They were unable to assist me right away and I had to get up. I lost my balance and fell on the floor. Nurse Practitioner made aware with order to send to local hospital due to R1 hitting his head and busted lip. R1 strongly refused and verbalized Absolutely not. I'm fine. I don't want to go through all of that. I feel fine.On 10/10/25 at 10:54AM, V4 (LPN), Nurse of R1 on 7/30/25 and 8/1/25 on the skilled unit, stated dialysis nurse reported R1 fell towards the end of R1's treatment. Per V4, R1 reported R1 could not wait for them to disconnect him. They were all with other patients. R1 could not wait and R1 was inpatient. V4 reported on 8/1/25 that it was reported by the dialysis nurse that R1 was inpatient and wanted to get up right away. R1 fell and hit his head and busted his lip and had a skin tear on the lip. V4 was able to control the bleeding. V4 stated R1 refused to go to hospital and Neuro check initiated and no changes with R1. V4 reported V4 documented the same exact scenario on both falls because it was the same scenario that R1 could not wait and got up. V4 stated the verbatim documentation on both days just happened, and V4 stated V4 did not realize V4 documented it exact verbatim. On 10/10/25 at 12:46PM, V6 (RN) dialysis nurse stated on 7/30/25 fall incident, R1 was cramping and V6 went to R1's chair side to turn off the UF (ultrafiltration) to help ease off the cramping. Blood Pressure was ‘okay', alert and oriented. V6 left R1 chair side and programmed the BP (Blood Pressure) check every 15 mins. V6 left the chair side and after few minutes R1 was complaining again with cramping on the legs. As soon as R1 verbalized cramping, R1 stood up and lost his balance and fell on the floor. R1 was in V6's clear view. V6 stated she was at the nurse's station, approximately 10 steps away from R1. Per V6, regarding the fall on 8/1/24, R1 complained of cramping. V6 stated they already knew R1 fell the last time R1 was in dialysis, so we went to R1 as R1 was trying to stand up to make sure R1 wouldn't fall again. R1 was trying to stand up at the time. All three-dialysis staff were surrounding R1. R1 started shouting ‘back off' and was motioning of pushing us away. We explained to R1, we just wanted to make sure he is safe because he fell in treatment before. R1 eventually was able to sit down. We gave him his space. V6 turned around and heard a thud noise while walking away and halfway to the nurse's station. There was blood on the bottom lip. We helped him untangled the lines and R1 was able to get back on the chair with stand by assist. On 10/10/25 at 10:19AM V3 (Restorative Nurse/Fall Coordinator) stated when an incident happened, we made sure we did the investigation right away to find the root cause. Post fall huddle. New intervention will be added in the care plan. V3 stated R1 had a fall incident on 7/30/25 at 10 am, fell towards the end of dialysis treatment. V3 stated R1 reported R1 was having cramps in his leg. R1 needed to get up and lost his balance. There was dialysis staff present when the incident happened. Root cause for this fall was non complainant and behavior of R1. Per V3, the fall on 8/1/25 at 10AM, R1 lost his balance and fell on the floor. V3 stated this happened again in the dialysis unit. R1 initially was moderate risk for fall upon admission and became high risk for fall after the fall on 7/30/25. Intervention is to reeducate about safety reminder not to get up by himself.Record reviewed: R1 has