

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Elevate Care Waukegan		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Audrey Nixon Boulevard Waukegan, IL 60085	
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 0921 Level of Harm - Actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a light fixture was in safe operating order. This failure resulted in the light fixture falling from the ceiling, landing on the resident while in bed, and R1 sustaining a second degree burn. This applies to 1 of 3 residents (R1) reviewed for safe physical environment in the sample of 3. The findings include: R1's electronic face sheet documents R1 has diagnoses that include peripheral vascular diseases, left leg amputee, and hypertension. R1's facility assessment, dated 10/3/25, show R1 has no cognitive impairment. R1's Emergency Department (ED note), dated 10/6/25, documents, Patient presented from facility burned to right upper arm. EMS stated light fixture caught on fire and plastic pieces came down on patients' right arm second degree burn noted. Patient alert and denied shortness of breath said he was in his room when the light fixture above had a clot fire and melted plastic pieces dripped down his arm, patient complaining of pain in his right upper arm-skin: warm to touch, 14x 7 centimeter (cm) with blanching erythema as well as epidermal desquamation, the distal palmar surface of the left middle finger has mild blanching erythema. Diagnoses: second degree burns with deep and superficial partial thickness burn-right upper arm as well as superficial partial thickness burn of the palmar aspect of his distal left middle finger due to melted plastic without evidence of infection, tetanus updated in the ER patient was given pain med-improvement of pain. R1 was discharged with topical antibiotic ointment applied three times a day-TID. On 11/18/25 at 10 AM, R1 was alert and pleasant lying in bed. A dressing was noted to his right upper arm. R1 stated, That time when I got burned, I was eating my cereal for breakfast, all of a sudden the light fixture on the ceiling above me exploded, the plastic covering fell on me, it was so hot it burned me it hurt so bad (pointing to his right upper arm), my blankets, my hospital gown were on fire, I was yelling for help! R1's left middle finger redness had subsided. V2 (Director of Nursing) removed R1's dressing. R1's right upper arm was still reddened with several small open areas with clear drainage noted. V2 said R1's right upper arm that was burned was being treated with antibiotic ointments covered with dry dressing. On 11/19/25 at 9:30 AM, V4 (Registered Nurse-RN) said she was R1's Nurse last 10/6/25. V4 (RN) said she was outside R1's room passing morning meds when she heard R1 yelling for help. V4 said she went to R1, there was fire in the ceiling above him; there was fire noted on the side of his bed. V4 said she screamed, help, fire! fire! as she was pulling R1's bed away from the ceiling. V4 said V5 (Certified Nursing Assistant-CNA) came to help pull R1 away from the fire. 911 was called. R1 was sent to the ER. R1 came back to the facility with second degree burns. On 11/18/25 at 1:36 PM, V5 (CNA) said that day (10/6/25) he was collecting breakfast trays from rooms as breakfast was just finishing, when he heard loud screams coming from R1's room. V5 said he ran towards R1's room, the Nurse (V4) was already there pulling R1 in his bed for safety away from the ceiling. A ceiling tile fell on top of R1, smoke was noted in the ceiling, fire sparks were noted in R1's covers. R1 was shocked and confused. R1 was noted to have burned areas in his right upper arm. 911 was called. A fire extinguisher was used to spray the ceiling to stop the fire. On 11/18/25 at 11 AM, V7 (Maintenance Director) said it was around 8:30 in the morning on 10/6/25, a code red was initiated indicating a fire on the 4th floor. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145669
		If continuation sheet Page 1 of 2

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0921 Level of Harm - Actual harm Residents Affected - Few	V7 said he hurriedly went to 4th floor, staff have extinguished the fire. At this time, the fire alarm had been activated, and Fire Department arrived (EMS). EMS cleared the code red. R1 was transported to the hospital via 911. V7 said investigation shows the cause of the fire was a light fixture in the ceiling. There was a loose contact that caused overheating and fire. The light fixture was still the original one years ago. V7 said prior to the incident, the preventive maintenance was just to go around looking for broken bulbs and replacing them. After this incident, (when R1 sustaining second degree burns) all the light fixtures have been checked. All light fixtures have been replaced with LED lights. V7 said an Electrician Company came to check the facility. An electrician report, dated 10/6/25, showed, Called to the facility why a light fixture caught on fire. Noticed that the plastic covering on the LED T8 bulb was melted and the end of the lamp was burnt (sic). We walked through the other residence (sic) room and took note of lamps that were not working but did not notice any arcing or discoloration on any of the other light fixture. On 11/19/25 at 9:30 AM, V1 (Administrator) said all lights were now in good working order and continue to educate staff to report any defective light fixture. V1 also said a reportable was sent to the state agency. The Facility Reported Incident sent to the state agency as final, dated 10/10/25, documents: On 10/6/25 at 8:30 AM, code red was initiated indicating a fire, staff immediately responded to the 4th floor room [ROOM NUMBER] (R1's room) During the code, staff retrieved fire extinguisher and put out the small flame. 911 was notified, fire department responded cleared the code red. (R1) was transported to the local hospital. Initial root cause analysis showed the light fixture malfunction in (R1's) room, light fixture melted onto the bed of (R1). Ballast connection to the light bulb became too hot and sparked. All preventive maintenance was reviewed and note that there were no issues with any light bulb in the building, staff educated on what to do if observing a malfunctioning light fixture. The Facility Policy on Environmental Services, (undated) documents, to ensure that the facility is designed, equipped and maintained in accordance with all governing rules and regulations and standards.		