STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that staff follow professional standards of practice of carrying out physician orders for one resident (R3) and failed to document resident assessment in medical record for five residents (R2, R3, R4, R5, R6) These failures affected five residents (R2, R3, R4, R5, R6) of six residents reviewed for nursing care, and have the potential to affect all 125 residents at the facility.Findings include:R3 is [AGE] years old and has resided at the facility since 2023, past medical history includes : Alzheimer's disease unspecified, encounter for attention to gastrostomy, adult failure to thrive, hypothyroidism, unspecified convulsion, malignant neoplasm of left kidney except renal pelvis, pressure ulcer of right elbow stage 3, pressure ulcer of sacral region stage 4, fall on same level from sipping, tripping and stumbling, essential primary hypertension etc.On 4/7/2026 at 3:49PM, V19 (Infectious Disease Nurse Practitioner) said that she is familiar with R3 and has been in his case since January. R3's wound was infected as indicated in January wound culture. R3 had a debridement recently and has been on antibiotics since January. V19 said that she ordered a repeat wound culture but do not think it was collected.Review of medical records showed wound culture dated January 16, 2026, that was positive for Klebsiella pneumonia and Enterococcus faecalis. Review of physician orders for R3 showed three orders to obtain wound culture by V19 dated 2/7/2026, 2/18/2026 and 3/18/2026.On 4/8/2026 at 3:15PM, V2 (DON/Director of Nurses) said that they do not have the result for the wound cultures ordered for R3 on 2/7/2026 and 2/18/2026 because they were not completed, resident was at the hospital on 3/18/2026 and that order could not be completed. The purpose of the blood culture is to get appropriate antibiotics for resident's wound, the ordered culture should have been collected, it is not standard of practice not to follow physician's order. V2 spoke to the two nurses that received the orders, they do not have any reason why they did not carry out the orders. The expectation is for the order to be carried out, cannot give a definite reason why the orders were confirmed when they were not carried out.R2 is 65 years and has resided at the facility since 2024, face sheet listed the following past medical history: quadriplegia C5 to C7 incomplete, encounter with attention to gastrostomy, type 2 diabetes, anxiety disorder, neurogenic bowel, retention of urine, etc.R4 is 91 years and have resided at the facility since 2023, past medical history includes : Unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, chronic kidney disease unspecified, altered mental status, hypokalemia, dysphagia oral phase, muscle wasting and atrophy, not elsewhere classified, multiple sites difficulty in walking , gastrostomy status, unspecified osteoarthritis, hyperlipidemia, etc.R5 is [AGE] years old and have resided at the facility since 2023, past medical history includes: Dysphagia following cerebral infarction, encounter for attention to gastrostomy, presence of cardiac implants and grafts, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, hyperlipidemia, essential primary hypertension, Alzheimer's disease, peripheral vascular disease, non- pressure chronic ulcer of left heel, diabetes mellitus, etc.R6 is 82 years and has resided at the facility since 2023. Past medical history includes, but not limited to pressure ulcer of sacral region stage 4, hypertensive heart and chronic kidney disease with heart (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure stage 1 through stage 4, chronic systolic (congestive) heart failure, encounter for attention to colostomy, anemia unspecified, major depressive disorder, retention of urine, etc.Active physician orders for R2, R3, R4, R5, and R6 show the following order: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form. Every day shift every Mon, Thu for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt. If answer is YES to the new skin alteration - document, it under the NUR Skin Assessment Form.Review of shower sheets for the months of January, February and March for R2-R6 did not show any documentation of skin assessment, there was no documentation of skin assessment in any other part of medical record for these residents.On 4/7/2026 at 11:22 AM V18 (Wound Licensed Practical Nurse/LPN) stated that CNA (Certified Nurse Assistant) will call the nurse to do a skin check on each resident before their shower. If a bed bath is given, the nurses would still have done a head-to-toe assessment. V18 stated that the nurses only document their head-to-toe skin assessment on the CNA Shower Sheet. It is not documented anywhere else.On 4/7/2026 at 1:36PM, V20 (LPN/Treatment Nurse) said that nurses are supposed to do skin assessment as ordered and any skin alterations both old and new should be documented in shower sheets.On 4/7/2026 at 2:50PM, V2 (DON) said that showers are supposed to be completed according to the schedule and documented in medication administration record (MAR). Shower sheet is signed by nurses to show what is going on with the resident and collected by wound care. Nurses inspect the skin when shower or bed bath is given but are not required to document the condition of the skin in the shower sheet or resident's record. Nurses only have to put their initial in the medication administration record (MAR). V2 said that the facility does not have any policy stating that nurse's initial in the MAR is the only documentation required for skin assessment.Physician orders entering and processing policy revised 1/31/2026 stated its purpose as to provide general guidelines when receiving, entering and confirming physician or prescriber's orders. (a prescriber is noted as physician, nurse practitioner, and a physician's assistant).Guidelines: 5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under clinical> orders>pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed.Job description for registered nurse (RN) and licensed practical nurse (LPN) (undated) stated in part: The RN/LPN is responsible for providing direct nursing care to residents and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility, and ---------- to ensure that highest degree of quality care is always maintained.Essential duties and responsibilities:Complete and file required record keeping forms/charts upon resident's admission, transfer and /or discharge. Receive and transcribe telephone orders from physicians and record on the physician order form. Chart nurse's notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that staff provide scheduled shower for residents who were dependent on staff for Activities of Daily Living (ADL) and failed to ensure that skins assessments were completed and documented as ordered. This failure affected five residents (R2-R6) of five residents reviewed for ADL care.Findings include:On 4/6/2026 at 1:50PM R2 was observed in her room, awake, alert and oriented x2 to 3, stated she has been at the facility for about 3 years, the certified nurse assistants (CNAs) do not change her, she does not get out of bed only once in a while when they decide to take to the shower room. R2 said that she does not get her scheduled showers, gets bed bath most of the time but she would like to have showers because she likes water on her.On 4/6/2026 at 2:10PM, V5 and V4 (CNAs) walked into R2's room while the surveyor was talking to the resident, stating that they came to take her for a shower, she is scheduled on Monday and Thursday on Am shift. R2 said that the last time she had a shower was 2 weeks ago, the surveyor asked V4 and V5 the last time R2 was showered, and they both said they do not know. Both CNAs stated, the showers are documented on the shower sheet and placed in a binder at the nursing station.On 4/6/2026 at 3:09PM, V9 (R2's family member) said that R2 does not get her shower two times a week as scheduled, staff does not assist her with brushing her teeth, V9 has spoken to staff about the care R2 is receiving but nothing has changed.R2 is 65 years and has resided at the facility since 2024, face sheet listed the following past medical history: quadriplegia C5 to C7 incomplete, encounter with attention to gastrostomy, type 2 diabetes, anxiety disorder, neurogenic bowel, retention of urine, etc.Active physician order for R2 reads as follows: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form. Every day shift every Mon, Thu for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt. If answer is YES to the new skin alteration - document, it under the NUR Skin Assessment Form. Order date 3/17/2026.Minimum Data Set (MDS) assessment section C (cognitive pattern) scored R2 with brief interview for mental status (BIMS) score of 14, section gg (functional) of the same assessment documented that R2 requires maximal/substantial assistance from staff for all ADL care needs.Care plan initiated 3/18/2026 documented the following: monitor skin during care and report any changes, Offload bony areas using pillows, foam wedges, and/or offloading devices, Turn and reposition at least every 2 hours while in bed and as needed, reposition at least hourly while in wheelchair and as needed, etc.R3 is [AGE] years old and have resided at the facility since 2023, past medical history includes : Alzheimer's disease unspecified, encounter for attention to gastrostomy, adult failure to thrive, hypothyroidism, unspecified convulsion, malignant neoplasm of left kidney except renal pelvis, pressure ulcer of right elbow stage 3, pressure ulcer of sacral region stage 4, fall on same level from sipping, tripping and stumbling, essential primary hypertension etc.From 4/6/2026 to 4/8/2026 between 9:15AM and 2:38PM, R3 in bed lying on his back, floor mat x2, G-tube infusing, wound vac noted at bed side connected to resident, foley in privacy bag. R3 is scheduled to receive showers twice a week as documented in the following physician order: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form, every day shift every Wed, Sat for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt. If answer is YES to the new skin alteration - document it under the NUR Skin Assessment Form.Review of shower sheets for the past three months shows the following: In January 2026, R3 received 3 of the 9 scheduled showers. In February 2026 R3 received 3 of the 8 scheduled showers. In March 2026 R3 received 2 out of 5 scheduled showers. Additionally, 1 shower was given on a non-scheduled shower day. One shower was documented as being done on 3/25/2026, but R3 was hospitalized on that date. This (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation was presented to V18 (LPN/Wound care) who stated that a shower would not have been possible since the resident was not at the facility. MDS assessment dated [DATE] coded R3 with a BIMs score of 3, indication memory problem, section gg (functional abilities) of the same assessment documented that R3 is dependent on staff for all ADL care needs, section h (bowel and bladder stated that R3 is frequently incontinent of bowel.R4 is 91 years and have resided at the facility since 2023, past medical history includes : Unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, chronic kidney disease unspecified, altered mental status, hypokalemia, dysphagia oral phase, muscle wasting and atrophy, not elsewhere classified, multiple sites difficulty in walking, gastrostomy status, unspecified osteoarthritis, hyperlipidemia, etc.R4 has the following active orders: Weekly Showers/Skin Assessment.Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form. every evening shifts every Tue, Fri for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt. If answer is YES to the new skin alteration - document, it under the NUR Skin Assessment Form.Review of shower sheets for January, February and March for R4 showed that in January 2026 R4 received no showers or bed baths. In February 2026, R4 received 4 of the 8 scheduled showers. In March 2026 R4 received 2 of the 9 scheduled showers.MDS assessment dated [DATE] section C (cognition) was grayed out and did not indicate any BIMs score for R4, section gg (functional of the same assessment indicated that r4 is dependent on staff for all ADL care needs.R5 is [AGE] years old and have resided at the facility since 2023, past medical history includes: Dysphagia following cerebral infarction, encounter for attention to gastrostomy, presence of cardiac implants and grafts, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, hyperlipidemia, essential primary hypertension, Alzheimer's disease, peripheral vascular disease, non- pressure chronic ulcer of left heel, diabetes mellitus, etc.On 4/6/2026 at1:05PM, R5 was observed in bed lying on her back and could not respond to questions, floor mats x2, bed to the floor, G-tube feeding at bedside but not connected to R5. On 4/7/2026 at 11:27AM, Resident still in bed lying on her back, nonverbal but opens her to greeting, G-tube infusing at 75ml per hour.On 4/8/2026 at 8:43AM, Resident in bed lying on her back for the third day, awakes to greeting and shook her head yes when asked if she is doing okay. G- tube feeding and water flush bag dated 4/8/2026, pump on hold. At 8:45AM, observed wound care for R5 with V18 and V20 (LPN/wound Care), and observed a large area of maceration on resident's sacrum, area was cleaned with normal saline and new treatment applied by V18. R5 had an incontinence brief that was saturated with urine prior to wound care. Active physician order for R5 showed the following: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form. Every evening shifts every Wed, Sat for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt, if answer is YES to the new skin alteration - document it under the NUR Skin Assessment Form.Shower sheets for R5 for the months of January, February and March 2026 showed the following: In January 2026, R5 received 3 of the 9 scheduled showers. In February 2026 R5 received 6 of the 8 scheduled showers. In March 2026 R5 received 7 of the 8 scheduled showers.R6 is 82 years and has resided at the facility since 2023. Past medical history includes, but not limited to pressure ulcer of sacral region stage 4, hypertensive heart and chronic kidney disease with heart failure stage 1 through stage 4, chronic systolic (congestive) heart failure, encounter for attention to colostomy, anemia unspecified, major depressive disorder, retention of urine, etc.R6 has the following active order: Weekly Showers/Skin Assessment. Acknowledgment of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete NUR Skin Assessment Form. Every evening shifts every Mon, Thu for Weekly Showers/Skin Assessment. If answer is NO to shower - document the refusal or resident being OOP or appt. If answer is YES to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new skin alteration - document, it under the NUR Skin Assessment Form.On 4/7/2026at 9:29 AM, surveyor interviewed R6 who said, I am in bed all of the time, they give me a bath in bed, but not too often.On 4/8/2026 at 8:40 AM, R6 stated that she went to get a shower once a long time ago. I get bed baths. My hair has not been combed in over a year. I've asked them to wash my hair, but they don't seem to have time. I can pay for a beautician to come in if they don't have time to wash my hair. I like to be clean.Review of shower sheets for R6 for the past three months showed the following: In January 2026, R6 received 3 of the 8 scheduled showers, additionally 2 showers were given on non-scheduled shower days. In February 2026, R6 received 3 of the 8 scheduled showers. In March 2026 R6 received 5 of the 9 scheduled showers.MDS assessment dated [DATE], section C (cognition) scored r6 with a BIMs score of 15, indicating that resident is cognitively intact, section gg (functional status) of the same assessment indicated that R6 is dependent/ substantial/maximal assistance from staff for most ADL care needs.On 4/7/2026 at 11:22 AM V18 (Wound Licensed Practical Nurse) stated that each resident receives a shower twice a week and as needed. On the shower days, the Certified Nursing Assistants (CNA) take the residents into the shower room. Upon disrobing of the resident, the CNA will pull the call light for the nurse to do a skin check on each resident before their shower. Once the nurse completes the skin check, the CNA completes the shower. For every shower, the CNAs complete a CNA Shower Sheet. V18 stated that if there is no shower sheet, that means that the shower was not given. The wound care tech files the CNA Shower Sheet in binders. When a resident does not receive a shower, a bed bath should be given, but that would be documented on the shower sheet with a handwritten note by the CNA that a bed bath was given instead of a shower. If a bed bath is given, the nurses would still have done a head-to-toe assessment. V18 stated that the nurses only document their head-to-toe skin assessment on the CNA Shower Sheet. It is not documented anywhere else. V18 added that if a resident does not get a shower or bed bath and doesn't get a head-to-skin assessment from the nurse, the risks include additional skin breakdown, new skin abnormalities, and the fact that the nurse does not get an overall look at the resident. There is also a risk of infection due to uncleanliness. Depending on the resident, it can be emotional. V18 stated that the overall care is poor if the resident is not getting a bath, shower or head to toe assessment. V18 stated that a bed bath is not as thorough as a shower.On 4/7/2026 at 11:22 AM V18 (Wound Licensed Practical Nurse) stated that CNA will call the nurse to do a skin check on each resident before their shower. If a bed bath is given, the nurses would still have done a head-to-toe assessment. V18 stated that the nurses only document their head-to-toe skin assessment on the CNA Shower Sheet. It is not documented anywhere else, if there is no shower sheet, then the shower is not done.On 4/8/2026 at 12:35 PM V26 (Certified Nursing Assistant/CNA) stated that the CNA shower Sheets are completed for every resident on their assigned shower day. Whether the resident has a shower, has a bed bath, or refuses; we will have a shower sheet for every resident on their assigned shower days. If we see a change in their skin, whether it is old or new, we will make sure that it is documented. We can document a change in the skin, or the nurse documents it, but the nurse does the assessment and signs off on the sheet. The nurse looks for any wounds or cuts or bruises or rashes, really any skin abnormality. If it is an old injury or change in the skin, it will still be on the shower sheet. The nurse is required to fill out the shower sheet. Sometimes the nurse does it before the shower or bath or sometimes after, but the nurse sees every resident. If the resident refuses a shower or bath, the nurse knows that too because the nurse is the last one to sign the sheet and we fill out a sheet for every resident. It is mandatory that we have a shower sheet for every resident on every shower day that they are scheduled. The shower sheet will either be filled out, or the shower sheet would say bed bath if the resident wanted a bed bath, or the shower sheet would say refused if the resident refused a bath or shower. It is a dignity issue.Surveyor requested for any documented skin assessments for R2-R6 but none was provided.Policy titled Bathing - Shower and Tub Bath revised 1/31/2018 stated in part that the purpose is to ensure resident's cleanliness to maintain proper hygiene and dignity. A shower, tub bath or bed/sponge bath will be ordered according to a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's preference two times per week or according to the resident's preferred frequency and as needed or requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to provide services to promote wound healing by failing to obtain wound cultures as ordered for one (R3) of three residents reviewed for pressure ulcer. Findings include:R3 is [AGE] years old and has resided at the facility since 2023, past medical history includes: Alzheimer's disease unspecified, encounter for attention to gastrostomy, adult failure to thrive, hypothyroidism, unspecified convulsion, malignant neoplasm of left kidney except renal pelvis, pressure ulcer of right elbow stage 3, pressure ulcer of sacral region stage 4, fall on same level from sipping, tripping and stumbling, essential primary hypertension etc.MDS assessment dated [DATE] coded R3 with a BIMs score of 3, indicating severe cognitive impairment, section gg (functional abilities) of the same assessment documented that R3 is dependent on staff for all ADL care needs, section h (bowel and bladder) stated that R3 is frequently incontinent of bowel. From 4/6/2026 to 4/8/2026 between 9:15AM and 2:38PM, R3 in bed lying on his back, could not be interviewed due to cognitive decline.Hospital record dated 3/25/2026 documented principal/secondary diagnosis as necrotic sacral wound status post excisional debridement skin, soft tissue and muscle form necrotic sacral ulcer (18cm (centimeters) x16cm x 3.5cm depth) on 3/20/2026 by the surgeon. The same record continued in part: R3 is [AGE] year-old male with history of Alzheimer's dementia, hypothyroidism., who presented from nursing home due to concern for infected decubitus wound.CT abdomen pelvic: sacral decubitus ulcer extending to bone with locules of air tracking within soft tissues, surgery consulted and completed OR (Operating Room) debridement on 3/20/2026. ID (Infectious Disease) also consulted for antibiotics supported. Initial wound culture with Klebsiella pneumonia, Enterococcus faecalis, and Proteus mirabilis. R3 was treated with Zosyn for several days and discharged on Augmentin.On 4/7/2026 at 1:36PM, V20 (LPN-Licensed Practical Nurse/Treatment Nurse) said that R3 went to the hospital to follow up on a wound infection, resident was being followed by wound care three times a week and seen by the wound doctor once a week on Thursdays. The last picture of resident's wound was taken on 3/9/26. The measurements are: 12.00 x11.00 x2.80 (Length x Width x Depth-L x W x D) no infection was detected on the 16th but due to tissue changes, resident was sent out, he was already on antibiotics.Wound assessment detail report dated 3/2/2026 documented unstageable pressure ulcer measuring 13.00 x 14.00 x 2.80 (L x W x D) exudate - amount heavy, type serosanguineous.Wound detail assessment report dated 3/16/2026 documented the same wound with a measurement of 16.00 x 15.00 x 2.80 (L x W x D), same amount and type of exudate. Both assessments documented that resident was not on antibiotics.On 4/7/2026 at 3:49PM, V19 (Infectious Disease Nurse Practitioner) said that she is familiar with R3 and has been in his case since January. R3's wound was infected as indicated in January wound culture. R3 had a debridement recently, V19 ordered for a repeat wound culture but do not think it was collected. V19 said that the treatment resident was receiving was tailored to the result of the January wound culture, the wound showed improvement initially and then stopped. V19 said that R3 has been on an antibiotic, someone should have followed up on the wound culture order, the result could have given a different direction of treatment.Review of medical records showed wound culture dated January 16, 2026, that was positive for Klebsiella pneumonia and Enterococcus faecalis. R3 has three orders to obtain wound culture by V19 dated 2/7/2026, 2/18/2026 and 3/18/2026.Practitioner progress notes by V19, date of service 3/11/2026 documented in part: 2/18/26 ID for follow up on SSTI (Skin and Soft Tissue Infection). 2/14 labs revealed wbc (White Blood Cell Count)13.0, trending up. platelets 547, trending up. neutrophils 70.4, trending up. GFR (Glomerular Filtration Rate)102. CRP (C-reactive protein)16.82 ESR (Erythrocyte Sedimentation Rate) 126. Concern for worsening SSTI. Will start Ampicillin, Zyvox. wound cx (culture) reordered. 2/23 labs revealed wbc 12.3, platelets 705, neutrophils 63.8. ESR 127, CRP 16.9. Will continue to trend labs, awaiting wound culture, wound care following, recommendations appreciated.On 4/8/2026 at 3:15PM, V2 (DON-Director of Nursing) said (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that they do not have the results for wound cultures ordered for R3 on 2/7/2026 and 2/18/2026 because they were not completed. Resident was at the hospital on 3/18/2026 and that order was not completed. The purpose of the blood culture is to get appropriate antibiotics for resident's wound, the ordered culture should have been collected, it is not standard of practice not to follow physician's order. V2 spoke to the two nurses that received the orders, they do not have any reason why they did not carry out the orders. The expectation is for the order to be carried out and cannot give a definite reason why they confirmed the orders when they were not done.On 4/13/2026 at 10:03AM, V28 (Wound Doctor) said that he is not a fan of giving antibiotics to older people. When asked if the ordered wound culture for the resident should be collected and if it would have helped in the treatment, V28 said, ask the facility, they might have a reason why it was not collected, I don't think I ordered it.Physician orders entering and processing policy revised 1/31/2026 stated its purpose as to provide general guidelines when receiving, entering and confirming physician or prescriber's orders. (a prescriber is noted as physician, nurse practitioner, and a physician's assistant).Guidelines: 5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under clinical> orders>pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed.Job description for registered nurse (RN) and licensed practical nurse (LPN) (undated) stated in part: The RN/LPN is responsible for providing direct nursing care to residents and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility, and.to ensure that highest degree of quality care is always maintained.Essential duties and responsibilities:Complete and file required record keeping forms/charts upon resident's admission, transfer and /or discharge. Receive and transcribe telephone orders from physicians and record on the physician order form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide individualized fall interventions for one resident (R1) out of three residents reviewed for falls. R1 was assessed as a high risk for falls upon admission, fell out of bed twice in one week, was found to be unresponsive after the second fall, code blue was called, resident was revived and sent to local hospital for further management.Findings include:R1 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following past medical history: chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, encounter to attention to tracheostomy, dependence on respirator/ventilator status, anorexic rain damage, encounter for attention to gastrostomy, anxiety disorder, etc.Fall assessment dated [DATE] documented a score of 71, indicating high risk for fall. Minimum data set (MDS) assessment dated [DATE] section C (cognition) did not have a brief interview for mental status (BIMS) score for R1, section gg (functional status) of the same assessment documented that R1 is dependent on staff for all activities of daily living (ADL) care needs, including rolling from left to right.Care plan initiated [DATE] for safety stated that R1 will be free of falls through the next review, interventions include providing hi-low bed, ensure in lowest position when resident in bed, sent to ER (Emergency Room), resident will be reviewed for appropriate intervention, upon return from hospital bilateral upper body wedges will be placed. Progress note dated [DATE] by V9 (LPN-Licensed Practical Nurse) documented in part: writer was summoned to room. resident was observed prone next to bed. bed was in lowest position. pt (patient) was assessed immediately. no injury, redness, or swelling noted. pt assisted back in bed via 4-person transfer. pt VS (vital signs) 173/99 p (pulse) 84 o2 (oxygen saturation) 98 trach/vent. Trach intact clean and patent. foley intact.Hospital record dated [DATE] documented in part: chief complaint gross hematuria. [AGE] year-old-male with past medical history ., presents to hospital for evaluation of gross hematuria. Nursing home reports patient sustained a fall at the facility yesterday and was found to have hematuria that began this morning.R1 was readmitted to the facility on [DATE] at 21:51 (9:51pm), at 22:19 (10:19), V9 (LPN) documented the following: 12:08am CNA summoned writer and respiratory therapist to the resident's room. pt was observed prone near bedside. Pt was assessed immediately. resident had no pulse, no rise and fall of the chest. code blue/CPR initiated at 12:15am. 911 was called at 12:16am 911 arrived at 12:26am. They took over code blue. family/ MD Notified.On [DATE] at 9:58AM, V9 (LPN) said that she is familiar with R1 and was present for his 2 fall incidents. The first fall occurred the day she came to work and shortly after rounding, about 12:00AM, resident was found prone on the floor by the CNA V9 assessed resident, he did not have any injuries, he was at the same baseline, vitals were stable V9 added that resident did not have any fall interventions except that his bed was at the lowest position and he had mittens, resident was slightly combative and moves a lot, but does not have any wedge or bolsters in his bed. On [DATE], V9 have just completed her rounds and started to gather supplies for the shift, the CNA was rounding at 12:00AM and found resident on the floor, CNA called V9 and the respiratory therapist and they went together to resident's room, his vent was disconnected, resident was unresponsive, code blue was called and the staff followed procedure.Hospital record dated [DATE] documented in part: Patient arrived from skilled nursing facility. Per EMS (Emergency Medical Services) patient had fallen from bed and a nurse thought patient was pulseless and initiated CPR for unknown amount of time. When EMS arrived, patient had stable vital signs and strong pulses. Patient remained with stable vital signs and with a pulse throughout transport. Physical exam documented Abrasion over left frontal scalp, CT of the head documented: No acute soft tissue abnormality. No skull fracture.On [DATE] at 11:30AM, V8 (R1's family member) said that R1 had a cardiac arrest in [DATE] and lost control of his body, his bed was kept low, but he did not have any bed rails or any other intervention to prevent him from falling, V8 requested for bed rail, bed bolster or any other (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145671	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care South Holland	16300 Wausau Street South Holland, IL 60473

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	assistive device to prevent R1 from falling out of bed but none was provided.On [DATE] at 1:43PM, V6 (respiratory Supervisor) said that he has worked at the facility for 2 years, is familiar with R1 and believes he was sent to the hospital because he fell out of bed, V6 is not aware of any injury. V6 cannot recall if R1 had any rails on his bed, he came back from the hospital on [DATE] and was sent out again on [DATE] around 12:08AM for another fall, V6 is not sure if resident has any bolsters on his bed but said that he had mats on the floor.On [DATE] at 3:42PM, V21 (CNA) said that she recalls R1 and was the assigned staff the day he had a fall, V21 said she changed R1 30mins before his fall, V21 was in another room when another CNA came to tell her that resident was on the floor, they called the nurse and they put resident back in bed using a sheet, the respiratory therapist was there too, V21 is not sure if resident is a fall risk, she did not get any report from previous staff, V21 is not sure if resident has any fall interventions.On [DATE] at 2:50PM, V2 (DON) said that he saw R1 after his first fall, he is a vent patient, staff reported that he was restless and moves to his left side, R1 fell and went to the hospital, he was not a candidate for bed rails, he came back from the hospital and fell again, R1 did not return to the facility, they could have worked on more interventions if resident came back.On [DATE] at 9:02AM, V27 (Respiratory Therapist) said that she recalls R1 and the day he had a fall, V27 did not witness the fall, was called by one of the nurses to help her in resident's room, when V27 got to the room R1 was face down on the floor, he was put back in bed, his vent was not disconnected, resident did not have any injuries upon assessment. V27 does not think resident has any rails on his bed, did not have any bolsters that she can recall, resident tossed around a lot, his bed was kept low.On [DATE] at 10:44AM, V29 (respiratory therapist) said that the day R1 had a fall, she was in the therapy room charting when someone came to get her, they went to resident's room and she saw R1 on the floor, his vent was disconnected and it was beeping, V29 said she is not sure she heard the beeping from the respiratory room but the sound is usually loud, V29 is not sure how long R1 was disconnected, she was unable to get a pulse or saturation, they called a code and started CPR, 911 was called, they arrived and took over CPR. V29 does not recall if resident had any injuries, or if he had any rails or bolster in his bed, not sure if resident was a fall risk, his bed was low and he had mittens on his hands, V29 does not recall any other fall interventions for R1.Fall prevention policy revised [DATE] stated its purpose as to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality assurance programs will monitor the program to ensure ongoing effectiveness.Standards: A fall risk assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical guidelines.Safety interventions will be implemented for each resident identified at risk