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	06/07/2026

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to follow policy and procedure; failed to document the administration of medications (controlled substance); and failed to document in a resident's medical record a fall with serious injury in a timely manner. These failures affected one resident (R1) of three residents reviewed for falls.Findings include:R1's face sheet documents and admission date of 3/21/25 and diagnoses that include but are not limited to tracheostomy, artificial opening of urinary tract, malignant neoplasm of abdomen, secondary malignant neoplasm of bladder, retention of urine, urogenital implants, and dysphagia.R1's BIMS (brief interview for mental status) score, dated 4/16/26, is 13 which indicates R1 is cognitively intact.R1 unable to be interviewed due to R1 being hospitalized as of 5/26/26.R1's progress note, dated 5/25/26 at 9:00pm; created date 5/26/26 at 9:16am, (over 12hours after R1's fall occurred) per V6 (Registered Nurse/RN), documents, in part, Pt (R1) noted to be alert x2-3 with confusion noted pt (R1) has hx (history) of anxiety requiring meds, recent falls and cancerous mass to right side hip contributing to impaired mobility and high fall risk. Pt (R1) frequently forgets and requires repeated reminders not to get out of bed without assistance, despite education and reinforcement of safety instructions. Pt (R1) attempted to get out of bed unassisted. Fall precautions remains in place including lowest bed position call light within reach nonskid footwear door opened for frequent rounding. Pt (R1) assessed no skin tear or bruise noted. Pain medication provided. Wife notified. V6's (Registered Nurse/RN) narrative was not documented in a timely manner (over 12 hours from the date and time of R1's fall).R1's Initial FRI (Facility Reported Incident), 5/27/26, documents, in part, Incident date: 5/27/26; Incident Category: Fall with physical harm or injury; R1 was observed on the floor. No change in LOC (level of consciousness) with baseline. Full body assessment completed, no visible injuries noted. No s/s (signs/symptoms) of pain manifested as of fall. Neuro check initiated. ROM (range of motion) was done to all extremities and were WNL (within normal limits). No lengthening/shortening of limbs noted. MD (medical doctor) notified, Family notified. R1 complained of pain, V9 (Nurse Practitioner) assessed R1 and noted abnormality to right lower extremity. Order received to transfer resident to ER (emergency room) for further thorough evaluation. Bed in low position, call light attached within reach and not triggered. POA (power of attorney) was notified of transfer. POA was agreeable to plan of care. R1 is admitted to hospital with diagnosis of Right Hip Fracture.On 6/5/26 at 3:10pm, V6 (Registered Nurse/RN) said, I was his (R1) nurse. R1 was found on the floor in a sitting position. He's (R1) right by the nurse's station, but we (staff) didn't get to him (R1) in time to prevent the fall. I assisted him (R1) to bed. Did an assessment. He (R1) was in pain, but he (R1) was pointing to the mass side for cancer. The same type of pain that R1 always complains of, not worse. Called family and physician and let them what's going on. That was the first time doing protocol for facility. I should have charted the incident as soon as it happened. I charted the fall in the morning cause I picked up a shift. My note should have been more descriptive. There's a lot that goes on and you rush and try to remember to do everything, I left at 11:30pm. I charted the paper when I gave him (R1) the narcotic. No, I didn't chart it in PCC (electronic documenting system). I administered it (Tramadol). I just wrote it down. Yes, I should have charted the pain medication in PCC.Record review of R1's, May 2026, Medication Administration Record (MAR) revealed no documentation indicating that R1 received (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tramadol following the fall that occurred on 5/25/26 at approximately 9:00pm. The MAR further documents that R1 did not receive any dose of Tramadol on 5/25/26. Documentation reflects that Tramadol was subsequently administered on 5/26/26 at 9:46am, prior to R1's transfer to the hospital.Record review of R1's Controlled Drug Receipt/Record/Disposition Form revealed documentation indicating that Tramadol was removed from R1's medication stock on 5/25/26 at 9:00pm. However, there was no documentation to indicate that the medication was subsequently administered to R1.On 6/6/26 at 10:07am, V2 (Director of Nursing/DON) said, Yes, I expect them (nursing staff) to do a detailed narrative and in a timely manner, when there is an incident like a fall, even if it's not a serious injury. We (facility) have to QA (Quality Assurance) falls and find causes and put interventions in place. No, V6's note for R1's fall does not describe what happened or could have happened. When giving controlled substances, they are supposed to be charted in the MAR (medication administration record) and not just signed off on the controlled sheet. They've been in-serviced on this.Record review of facility policy titled, Medication Administration Policy, dated 1/1/2015, documents, in part, Medications shall always be prepared, administered, and recorded by the same licensed nurse. Documentation of medication administration is recorded on the Medication Administration Record (MAR) or Treatment Record and includes the date, time, and initials of the licensed nurse who administered the medication. Class II Medications: Only a licensed nurse may - a) administer Class II medications and/orb) handle, carry, and/or use the controlled medication key. When Class II medications are administered, the medication is recorded on the Medication Administration Record by a licensed nurse.Record review of facility policy titled, Fall Prevention Program, dated 11/21/17, documents, in part, 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 assure ongoing effectiveness. The Fall Prevention Program includes the fallowing components: Assessment time frames; Use and implementation of professional standards of practice.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must be safe, clean, comfortable, and homelike.