STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. Building B. Wing	02/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Country Club Hill	18200 South Cicero Avenue Country Club Hills, IL 60478

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 - 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 interview and record review, the facility failed to implement fall preventive measures for a resident who is a 2 person transfer assist due to increased weakness and behaviors. This deficiency affects one (R1) of three residents reviewed for Falls prevention program. This failure resulted in R1 being hospitalized and treated for a Closed Fracture of Left ankle. Findings include:R1 is a [AGE] year-old admitted to the facility on [DATE] with the following diagnoses in part but not limited to: cerebral palsy, unspecified convulsions, spastic hemiplegic cerebral palsy, other disorders of muscle, reduced mobility, vascular dementia, essential hypertension, Paroxysmal atrial fibrillation, gastro-esophageal reflux disease, cardiomyopathy, hypothyroidism, autistic disorder, schizophrenia, bipolar disorder, generalized anxiety, unspecified fracture of shaft left fibula, depression,Facility Reported Incident dated 10/18/25 documents during transfer R1 was assisted by certified nurse aide, R1 was observed sitting on floor with her back to the bed with legs flat on the floor. R1 sustained Left Tibia Fibula Fracture.On 2/7/26 at 10:30AM, R1 said that she recalls when she fell and broke her ankle. R1 said that there was only one certified nurse aide present and was transferring her from bed to wheelchair and that the wheelchair was not positioned correctly and the certified nurse aide grabbed her from under the arms and stood her up and then let go of her from her left side and that's when she slid down to the floor. R1 said she has weakness to left arm. R1 said she was wearing her Ankle Foot Orthosis (AFO) brace and when she slid to floor, she heard a cracking sound and told the staff her leg hurt.On 2/7/26 at 11:27AM, V3 (Registered Nurse) stated she was unsure of what transfer status R1 was prior to the fall, V3 said she was the nurse on duty when R1 fell on [DATE]. V3 said there was only one staff member assisting her with the transfer on 10/18/25. R1 did sustain a fracture from fall. On 2/7/25 at 12:40PM, V5 (Licensed Practical Nurse) stated she was not aware of fall care plan intervention of two person transfer due to increased weakness and behaviors.On 2/7/26 at 1:40PM, V7 (Registered Nurse) stated that for all residents the care plan interventions are to be followed.On 2/7/26 at 2:20PM, V2 (Director of Nursing) stated that her expectations are for care plans to be updated as needed and staff to follow resident's interventions as indicated.On 2/7/26 at 2:35pm, V1 (Administrator) stated that care plans should be updated quarterly, annually and as needed and expect the staff to follow care plan interventions.The Post Fall Observation assessment dated [DATE]- indicating High Fall risk.GG self-care and mobility assessment dated [DATE] chair/bed to chair transfer- Dependent requiring two staff assist.GG- Functional Abilities and Goals assessment dated [DATE]- chair/bed to chair transfer- Dependent- requiring two staff assist.MDS section GG- Functional abilities dated 7/23/325- Putting on/taking off footwear- Dependent requiring two staff assist.MDS section GG- Mobility dated 7/23/25- chair/bed to chair transfer- Dependent requiring two staff assist.Care plan dated 2/22/23 R1 would benefit from use of left Ankle Foot Orthosis (AFO) Brace, related to diagnoses of cerebral palsy, spastic hemiplegic cerebral palsy, vascular dementia. Intervention: (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
	145967	A. Building B. Wing	02/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Country Club Hill	18200 South Cicero Avenue Country Club Hills, IL 60478

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 - Actual harm Residents Affected - Few	Observe for signs/symptoms of pain, discomfort or intolerance.Care plan dated 1/8/24 R1 is at risk for falls r/t gait/balance problems, poor communication/comprehension, history of falling, spastic hemiplegic cerebral palsy exhibits poor judgment exhibited by intentions placing self on floor. Interventions: Moderate to substantial assist x two staff with gait belt for all transfers due to increased weakness and behavior.Care plan dated 1/24/25 R1 has ADL Self Care Performance Deficit related to dementia and disease process of cerebral palsy. Presents with diagnosis of cerebral palsy. Noted with limitations to left foot requiring left ankle foot orthosis brace/boot. Requires mechanical Hoyer lift x two person assist with transfers. Non-ambulatory requires wheelchair for mobility.Care plan dated 4/30/24 R1 requires use of full body lift for transfers. Intervention: Full body lift with two person assist for all transfers. Facility Policy on Fall Prevention Program- revised 11/21/17Purpose: 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.Guidelines:The Fall Prevention Program includes the following components:-methods to identify risk factors-methods to identify residents at risk-assessment time frames-use and implementation of professional standards of practice-immediate change in interventions that were successfulPeriodic quality assurance audit activities of records relating to falls that exhibit adherence to facility policies and implementation of the plan of care.Standards:-A fall risk assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines.-A fall risk assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident.-Safety interventions will be implemented for each resident identified at risk.Fall/safety interventions may include but are not limited to:Direct care staff will be oriented and trained in the Fall Prevention Program.Each resident will be screened by a specialist therapist at the time of admission, quarterly, after each fall, as appropriate and with significant change in the residents' mental and functional abilities.Transfer conveyances shall be used to transfer residents in accordance with the plan of care.Facility Policy on Transfer-Manual Gait Belt and Mechanical Lifts- revised 1/19/18Purpose: In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents.Guidelines:5. The transferring needs of residents will be assessed on an ongoing basis and designated into on of the following:2=2 person transfer with gait belt (ONLY when use of mechanical lift is not possible)6. Resident transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed.