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	03/21/2026

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 - 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. Based on observation, interview, and record review, the facility failed to implement fall prevention intervention for a resident at risk for falls. This failure affected one (R5) resident reviewed for falls in the total sample of 5 residents. Findings include: On 03/20/2026 at 11:12am at the nurses' station with V6 (Certified Nursing Assistant), the Call Device monitoring screen indicated Alarm 24 minutes in R5's room and bed. On 03/20/2026 at 2:46pm, V6 stated the 24 minutes on the screen of the call device monitoring system means the call device was activated 24 minutes ago. On 03/20/2026 at 11:21am, there was a leaf beside R5's name. R5 was not in the room. On 03/20/2026 at 11:25am, R5 was seated on a wheelchair across the nurses station with other residents. R5 was wearing gray pants. Inquiring about his call device, R5 stated he had been waiting for 30 - 40 minutes for someone to respond to his call device; he got impatient and got the pants from his closet, put on the pants by himself, but he could not pull the pants all the way up and he was not covered from his behind. R5's pants waist band was on the level of his buttock, and his incontinent brief was visible. R5 stated he could not pull the pants up. R5 stated he did not get the help that he needed and still needed to put his socks on. R5 was wearing shoes with no socks on. On 03/20/2026 at 11:34am, V10 (Certified Nursing Assistant) stated he just got done helping a resident. V10 stated he checked him (R5) at 9am and he did not need anything at that time. V10 stated a resident should not be waiting for 24- 40 minutes because they need help. V10 stated the leaf by his name means he is a fall risk and if he (R5) activated his call device because he needed something, he (V10) should have answered the call device so he (R5) would not fall trying to get it for himself. V10 stated he (R5) uses sliding board to transfer. And he did not transfer him today. Inquiring if he got the gray pants for R5. V10 stated he did not get the pants for him; somebody might have gotten the pants for him. On 03/20/2026 at 11:49am inside R5's room, there was a sliding board on top of R5's bed. V10 stated he was not around when he (R5) transferred from the bed to his wheelchair; and during transfer using the sliding board, somebody should be supervising him so he would not fall. On 03/20/2026 at 11:52am with V10, R5 stated no one supervised him while he transferred himself using the sliding board and no one assisted him in getting his pants from his closet. R5 was not able to raise his left upper extremity and stated his left extremity had been weak for 4 years.On 03/21/2026 at 3:26pm, V11 (Evening Shift Nursing Supervisor/RN) stated the leaf by the resident's name on the doorframe means fall precaution, to mark whoever is at high risk for falling. Everybody is at risk for falls, but some are at high risk for falls. Standard precautions include bed in lowest position, call bell within reach, and call bell should be responded to right away. V11 stated if the careplan indicated the resident needed supervision, the expectation is to follow the care plan for the safety of the resident. V11 stated everybody should follow the care plan. If a resident uses a sliding board for transfer and is careplanned for supervision then there should be staff during transfer to maintain the safety of the resident. On 03/20/2026 at 12:54pm, V4 (Assistant DON) stated all residents are at risk for falls. The leaf beside the name of the resident means the resident is at high risk for falls. Interventions are individualized but the basic intervention include making sure the bed is in lowest position, call light and personal items within the reach of the resident, and call light answered promptly. V4 stated twenty four minutes is beyond the (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	range that it should be answered; 24 minutes is kind of a long wait already.On 03/20/2026 at 1:28pm, V5 (Rehab Director) stated he (R5) was discharged from rehab in 10/2025, and OT (Occupational Therapy) marked him as ?Set Up' for upper and lower body dressing. Set Up means staff will take his clothes out of the closet and hand them to him or set them up on bed or on desk. V5 stated the reason for that is because he is wheelchair bound, and he cannot get up on his own. Rehab gives recommendations to restorative, and it is expected of the staff to follow the recommendations made by rehab for safety reason. V5 stated he (R5) is impatient at times. It is the residual from the stroke. V5 stated she (V5) can see it that if he (R5) waited too long for someone to respond to his call device to get his clothing, he would get it himself and it is not safe for him to do that because he may fall. R5's (01/08/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating R5's mental status as cognitively intact. Section I - Active Diagnose. I0020. Primary medical condition. 01. Stroke. I8000. Additional Active Diagnoses: a. hemiplegia (paralysis) affecting left non dominant side, contracture right and left knee. Section GG -Functional Abilities. GG0120. Mobility Devices: C. Wheelchair. GG0130. Self-Care. G. Lower body dressing: 03 - Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. R5's (10/5/2025 - 10/28/2025) Occupational Therapy Discharge Summary documented, in part Diagnoses: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Patient will improve ability to safely and efficiently perform LB (lower body) dressing with Supervision or Touching Assistance with use of no adaptive equipment in order to facilitate ability to live in environment with least amount of supervision and assistance and return to prior level of skill performance. Met on 10/20/2025.R5's (10/17/2025 Target Date: 07/02/2026) care plan documented, in part Focus: Has an ADL (Activities of Daily Living) Self Care Performance Deficit related to Hemiplegia, Impaired balance, Limited ROM. Presents with joint limitations to left upper extremity and bilateral lower extremity. Transfers w/sliding board. Uses w/c (wheelchair) as primary source for mobility. Continue program for maintenance. Goal: Will maintain current level of function in ADLs. Interventions: ADL Snapshot: Presents with joint limitations to left upper extremity and bilateral lower extremity. Supervision for Transfers w/ (with) sliding board. Uses w/c as primary source for mobility. Uses sliding board for transfers. Encourage to use bell to call for assistance. R5's (Initiated: 10/04/2022, Target Date: 07/02/2026) care plan documented, in part Focus: Is at high risk for fall R/T (related to) Deconditioning and history of falls and impulsive behavior. Goal: will be free from injury related to falls. Intervention: 11/30 Remind resident to call for assistance before attempting to self-transfer. Encourage resident to call for assistance with needs. Keep call light and desired personal items within reach. R5's (1/8/2026) Quarterly Fall Scale Evaluation documented, in part Score: 41. Category: Moderate Risk for Falling. E. Gait: Weak. F. Mental Status: 2. Overestimates or forgets limits. R5's (03/2026) Documentation of Survey Report (point of care) was reviewed with no entry for the AM shift on 03/20/2026. The (2-2-18) Call Light documented, in part Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident call lights will be answered in timely manner. 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 2. All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered. The (11-17-17) Comprehensive Care plan documented, in part Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.The (11-21-17) Fall Prevention Program documented, in part Purpose: 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. Use and implementation of professional standards of practice. Communication with direct care staff members. 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. Safety interventions will be implemented for each resident identified at risk. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Fall/safety interventions may include but are not limited to: At the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. Call lights are answered promptly. Transfer conveyances shall be used to transfer residents in accordance with the plan of care.