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	04/08/2026

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 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 ensure that the LALM (Low Air Loss Mattress) was on the right setting (while in use) and failed to implement preventive interventions to prevent further decline for two (R6 and R7) of four residents. These failures affected R6 and R7 and have the potential to affect all 39 residents using LALM in the facility.Findings include:On 04/01/2026 between 10:51am to 11:06am, during R6's wound care observation with V7 (Wound Care Director), V14 (Wound Care Nurse), and V15 CNA (Certified Nurse's Aide) / Wound Care Aide. R6 observed on a LALM (Low Air Loss Mattress) set between 130lbs to 180lbs. V7 opened R6's wound site on the sacrum. The wound had a reddish color around the wound bed and blackish color in the center. V7 stated, The wound site is bruised. V7 stated, it might be from pressure at the site. Surveyor asked whether R6 would benefit from repositioning and relieve of pressure. V7 laughed and said, Yes. The surveyor asked V7 what was R6's weight. V7 stated, R6's weight is between 120lbs and 125lbs.On 04/01/26 between 11:17am to 11:30am, during R7's wound care with V7, V14 and V15. R7 was observed in the bed on a LALM set at 80lbs to 130lbs. The surveyor asked regarding the facility policy / protocol on use of LALM regarding the setting. Both V7 and V14 stated, the LALM should be set according to the weight of the resident. R7 stated, I'm about 120lbs. Surveyor asked what the right setting for R7 LALM would be. V7 stated it is set between 80lbs to 130ls which is the correct setting for R7.On 4/1/2026 at approximately 12:10pm, medical record showed recorded R7's weight history and it showed documentation that R7's weight was 136lbs. V2 DON (Director of Nurse's) who was present at the time stated the facility policy/ protocol is to set the LALM according to the weight of the resident.On 4/1/2026 at 12:50am, V7 was shown the LALM setting on R6's bed and V7 stated I will have to educate all these aides and nurses (nursing staff) about the setting on these mattresses. When asked about how often the settings should be checked. V7 stated, at least every shift and the floor nurses should make sure the settings are right. V7 stated, if the settings are wrong, it defeats the purpose of the LALM has been used for, which is to aid healing and prevent developing more pressure wounds.On 04/6/2026 at approximately 3:4pm, when V29 (Wound Care Physician) stated, if the LALM setting is not set correctly, it can affect them in some cases; patients can get more wounds. V29 stated, the purpose of LALM is to relief pressure on the pressure points and redistribute weights.R6's MDS dated [DATE] scored R6 BIMS as 01 indicating that R6 is cognitively impaired.R7 ?s medical record showed that R7 was admitted to the facility on [DATE] and the MDS is in progress.R6 and R7's medical record EPOS (Electronic Physician Order) showed physician order to check the setting on the LALM. This order was not followed.On 04/02/2026 at approximately 1:15pm, R7 LALM was set between 80lbs and 130lbs. V7 who was present at the time stated I just told them to check all these setting on all the residents on LALM and shook her head. V7 stated, in addition R7's LALM should be set between 130lbs and 180lbs.On 04/01/2026 at approximately 3:08pm, the facility presented the manual for setting the LALM and that documents that in general the pump and mattress is high quality and affordable air mattress system suitable for medium and high-risk pressure ulcer treatment. They have been specifically designed for prevention of bedsores and offer an affordable solution to 24-hour pressure area care. Intended use listed includes but not limited to reduce the incident of pressure ulcers while optimizing patient comfort.

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	04/08/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure insulin medication was stored in a locked medication cart when not in visual proximity of the nurse. This failure affected one (R3) of four residents whose insulin medication was left at bedside without a physician order. This failure has the potential to affect 37 residents residing on the 2nd floor in the facility. Findings include:R3's medical record listed diagnoses includes but is not limited to Type 2 diabetes mellitus with foot ulcer, other acute osteomyelitis right ankle and foot, type 2 diabetes with hyperglycemia, and anemia.R3's MDS (Minimum Data Set) scored R4's BIMs as 15 cognitively intact.On 03/31/2026 at 12:55pm, R3 observed sitting in wheelchair in the room. On R4 bedside table noted an insulin syringe with a liquid solution. R4 stated that it is insulin, the nurse left it on that table since the weekend and none of them came to pick it up. At 1:00pm, When this was shown to V30 LPN (Licensed Practical Nurse) and was asked about the facility policy/protocol on medication administration. V30 identify the solution in the syringe as insulin 20units and stated that I am not the nurse that left it there, it should not be left on the table. At 1:05pm, V30 stated that no medication should be left at the bedside without Doctor's order and R4 is not on any self-medication administration program. The surveyor asked how often rounds are made and whether this includes making sure the resident environment is hazard free. V30 stated we are not supposed to leave medication and sharps object around in the room.On 03/31/2026 at 1:11pm, V2 DON (Director of Nurse's) was made aware of this observation and spoke with V30 about what happened. At 1:16pm, V2 stated that this should never happen, syringes and medication should never be left in patient room without physician order.R3 physician order showed orders for Insulin Lispro injection solution 100UNIT/ML (insulin Lispro) inject 16 units subcutaneously with meals for diabetes give 16 units with meals 3x (three times) a day with start date 3/19/25. Humalog solution 100UNIT/ML solution injected as per sliding scale.Review of MAR from 03/25/2026 to date 03/31/2026 showed insulin were documented as given with no documentation that R3 refused insulin or was drawn and not given. The facility policy titled Administration procedures for all medications documents that the policy purpose is to administer medications in a safe and effective manner. Listed procedures include but are not limited to if resident refuses medication, document, and refusal on MAR (Medication Administration Record).