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	06/05/2026

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 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 follow its incontinence care guidelines by failing to provide timely incontinence care to dependent residents. This applies to 4 of 6 residents (R3, R4, R5, and R6) reviewed for incontinence care in a sample of 6.The findings include:1.R3 is a [AGE] year-old female admitted with cognition intact as per the MDS (minimum data set) dated 3/6/26. MDS also documented that R3 is dependent on toilet hygiene.On 6/2/26 at 10:10 AM, R3 was observed in her bed with a feces smell upon entrance, and R3 stated, They changed me earlier in the morning at around 4:00 AM by the night staff. I am waiting to be changed.On 6/2/26 at 10:13 AM, V7 (R3's assigned certified nursing assistant / CNA) checked on R3, and R3 was observed with a urine and feces-soaked wet adult briefs.On 6/2/26 at 10:13 AM, V7 stated, I was on the second floor. During breakfast time, they moved me to the fourth floor, and I didn't get a chance to change my people yet.A review of the care plan documented that R3 was care planned for an alteration in bowel and bladder control with interventions including Monitor for non-verbal cues indicative of need to use bathroom or to be toileted by staff.2.R4 is a [AGE] year-old male admitted with severe cognitive impairment as per the MDS dated [DATE]. MDS also documented that R4 is dependent on toilet hygiene.On 6/2/26 at 10:20 AM, R4 was observed on his bed and stated, I was changed last night, and I am waiting to be changed. I didn't get changed after last night.On 6/2/26 at 10:24 AM, V7 checked on R4, and R4 was observed with urine and feces-soaked bed linen and gown. A review of the care plan documented that R4 was care planned for risk of impaired skin integrity, with interventions including provide incontinence care when needed.3.R5 is a [AGE] year-old female admitted with mild cognitive impairment as per the MDS dated [DATE]. The MDS also documented that R5 is dependent on toilet hygiene.On 6/2/26 at 10:30 AM, R5 was observed in her bed and stated, The ladies (CNAs) are saying I have a sore on my buttocks. I am still waiting to be changed. They changed me last night. I put the call light, and the CNA said she would come and change me, but they didn't change me yet.On 6/2/26 at 10:34 AM, observed V8 (Restorative CNA) checked on R5, and R5 was observed with a soaked incontinent brief with brownish discoloration and a big, healed sacral wound (white scarred tissue).A review of the care plan documented that R5 was care planned for risk of impaired skin integrity, with interventions including provide incontinence care when needed.4.R6 is a [AGE] year-old male admitted on [DATE] with severe cognitive impairment as per the MDS dated [DATE]. The MDS also documented that R6 is dependent on toilet hygiene.A review of the wound assessment report dated 5/27/26 documented a chronic facility-acquired stage 4 wound (5.3 x 8.0 x 0.3 centimeter/cm).On 6/2/26 at 11:10 AM, observed V9 (CNA) checking on R6 and was observed with a heavy, wet incontinent brief with mild brownish discoloration.A review of the care plan documented that R6 was care planned for bowel and bladder incontinence with interventions including Check as required for incontinence. Wash, rinse, and dry the perineum. Change clothing as needed after an incontinence episode.On 6/3/26 at 11:10 AM, V4 (Wound Care Director) stated, It's very crucial to provide timely incontinent care for residents to prevent skin deterioration. Our staff is supposed to provide incontinence care for at least 2 hours. Prolonged exposure to feces/urine can cause skin irritation or skin breakdown.A review of the facility's Incontinence Care policy, revised on 4/20/21, documents (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the guidelines: Incontinence residents will be checked periodically in accordance with the assessed incontinence episode, or approximately every two hours, and provided perineal and genital care after each episode.The facility presented the Pressure Ulcer Prevention policy dated 1/15/18, document guidelines:Maintain clean/dry skin during daily hygiene measures.Inspect the skin several times daily during bathing, hygiene, and repositioning measures.