STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Windsor Park	2649 East 75th St Chicago, IL 60649

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 follow their fall prevention policy and safely transfer for one resident (R4). The facility failed to check the mechanical lift sling to ensure that the sling was safe for resident transfers. This failure resulted in R4 falling to the ground from a mechanical lift, causing R4 pain and being frightened every time the staff have to transfer R4. This failure affected one resident (R4) reviewed for falls. This past noncompliance occurred from 10/26/25 to 11/4/25. Findings include:R4's medical diagnoses include but are not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, essential hypertension, type 2 diabetes mellitus, obesity, peripheral vascular disease.R4's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, indicating R4's cognition is intact.R4's progress notes dated 10/26/25 at 5:20pm documents in part, CNA (Certified Nursing Assistant) called out for assistance to complete transfer from shower bed to bedroom. Resident fell on back side during transfer. Resident was alert and talking immediately after incident. Resident able to express pain and discomfort. Writer requested resident to hold steal (sic) while more assistance could be gathered. Aide stayed with resident while writer gathered assistance. Resident relocated to stretcher by the assistance of staff and EMT's (Emergency Medical Technician). Resident transferred to hospital for observation.R4's progress note dated 10/28/25 at 3:17pm documents in part, 10/26/25 - The resident had a documented fall today from an elevated surface. EMS was contacted due to the impact of the fall.On 01/26/26 at 11:17am V7 (Licensed Practical Nurse/LPN) stated that she was R4's nurse the day that R4 fell. V7 stated that she had seen V12 (Certified Nursing Assistant) struggling to adjust R4 in the mechanical lift and went to offer assistance. V7 stated that R4 was already on the mechanical lift when she went to assist V12. V7 stated that they were right at the door of R4's bedroom when R4 fell from the mechanical lift. V7 stated that they were trying to take R4 to R4's bed, the strap from the mechanical lift sling broke and R4 fell to the ground. V7 stated that R4 complained of some discomfort at the time of the fall. V7 stated that she instructed R4 not to move and instructed V12 to stay with R4 while she went to call 911. V7 stated that R4 was already on the mechanical lift when she went to assist V12 and she is unsure if V12 assessed the mechanical lift sling for wear and tear before placing it under R4.On 01/26/26 at 1:05pm R4 stated that after V12 (CNA) gave her a shower, V12 placed R4 in the hallway outside the door of R4's room. R4 stated that V12 then transferred R4 from the shower bed onto the mechanical lift. R4 stated that she was told by V12 that R4's room was too congested and would do the transfer to the lift in the hallway. R4 stated that after V12 lifted her up in the mechanical lift, V12 stated that something didn't feel right and started looking for help. R4 stated that V7 (Licensed Practical Nurse/LPN) came to assist with the transfer. R4 stated that at that time, the strap from the mechanical lift sling broke and R4 fell to the floor. R4 stated that when she fell to the ground, it felt like she fell on one leg and her (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 - Actual harm Residents Affected - Few	butt cheek. R4 stated that after the fall, her left leg began to swell, and she has been having pain since the fall. R4 stated that she is frightened every time the staff have to transfer her. R4 stated that since she fell, she has been receiving bed baths because she is paranoid to get in the shower and fall again. On 01/26/26 at 2:55pm V12 (CNA) stated that R4 was already up and in the dining area when she arrived at work at 3pm. V12 stated that she did not know that the staff on the shift before hers had placed R4 on a defective sling. V12 stated that she showered R4 with the mechanical lift pad still under R4. V12 stated that with the assistance from V7 (LPN), they attempted to transfer R4 to bed with the mechanical lift. V12 stated that while R4 was in the air on the mechanical lift, the mechanical lift strap broke and R4 fell to the floor. V12 stated that she did not notice the worn-out strap before she tried to transfer R4. V12 stated that the feet straps of the mechanical lift sling snapped and R4 fell to the ground on R4's buttocks. V12 stated that R4 was in pain after the fall. V12 stated that she took pictures of the broken mechanical sling strap after R4's fall.On 01/26/26 at 3:00pm surveyor reviewed four photos of a broken and frayed strap in V12's (CNA) cellular phone dated 10/26/25.On 01/27/26 at 10:32am V17 (Restorative Nurse) stated that all staff are trained to use the mechanical lift. V17 stated that the staff are trained to inspect for wear and tear of the mechanical lift sling. V17 stated that if a mechanical lift sling is worn out, the staff have been instructed to give it to her so that it can be replaced. V17 stated that staff should not use a sling with worn hooks to transfer a resident. V17 stated that a mechanical sling with worn hooks may result in the hooks tearing during transfer, causing injury to the resident and/or staff. V17 stated that being dropped from the mechanical lift can cause fear of it happening again. V17 stated that the sling should have been inspected prior to R4's transfer and even prior to the staff putting it under R4. V17 stated that transfers should not be done in the hallway unless absolutely necessary. V17 stated that the mechanical lift is for transfers and is not a transport device. V17 stated that R4 was dropped from midair in the hallway. V17 stated that R4 never made it to R4's room.On 01/27/26 at 11:13am V1 (Administrator) stated that after R4's fall from the mechanical lift, they believed that the sling may have had a defect. V1 stated that the sling that was used for R4's transfer was sent to the manufacturer for inspection. V1 stated that the manufacturer stated that there were no manufacturer defects with the sling. On 01/27/26 at 12:53pm V18 (Nurse Practitioner/NP) stated that after R4's fall, R4 had some increased swelling to R4's legs. V18 stated that R4 complained of pain after the fall. V18 stated that R4' nervousness and anxiety is something that can be anticipated after a fall.On 01/27/26 at 2:24pm V2 (Director of Nursing/DON) stated that a quick inspection of the mechanical lift sling could have prevented R4's fall. V2 stated that from a reasonable person's perspective, she would absolutely be in fear of being transported after a fall. V2 stated that the mechanical lift should be used for transferring residents and not to transport them. V2 stated that transferring R4 from the hallway to R4's bed would be considered as transporting.On 01/27/26 at 3:45pm V3 (LPN) stated that R4 has been refusing showers since R4's fall. V3 stated that since R4 has been refusing to shower, she has instructed the CNAs to give R4 a bed bath. V3 stated that she does R4's skin assessment that is supposed to be done during showers while the CNA is giving R4 a bed bath.R4's care plan dated 12/31/25 documents in part, R4 requires use of full body lift for transfer. Diagnosis includes hemiplegia/hemiparesis. R4 will have no complications using the full body lift to next evaluation.R4's care plan dated 12/31/25 documents in part, R4 is at risk for falls related to hemiplegia/hemiparesis and gait/balance problems. R4 will be free of minor related to injury through the review date.Update: Resident was being transferred via (mechanical) lift when (mechanical) lift strap broke bringing resident down to the floor. Laundry and CNA staff was in-serviced on recognizing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	deteriorating (mechanical) lift pads and the proper procedure of removing them from circulation.Facility's policy titled Fall Prevention Program revision date 11/21/17 documents 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. Guideline: The Fall Prevention Program includes the following components: Methods to identify risk factors. Use and implementation of professional standards of practice. Adherence to manufacturer's recommendation in use of alarm and medical devices and special care equipment. Standards:.Malfunctioning equipment will be immediately reported to maintenance for repair or removed from service.Facility's policy titled Transfers - Manual Gait Belt and Mechanical Lifts revision date 01/19/18 documents in part, Purpose: In order to protect the safety and well-being of the staff and resident, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of residents. Guidelines:. 4. Mechanical lift equipment shall undergo routine maintenance checks by the nursing and maintenance staff to ensure that equipment remains in good working order.Facility's mechanical lift operator's manual titled Manual/Electric Portable patient Lift dated 2013 documents in part, Using the Sling: Warning. After each laundering (in accordance with instruction on the sling), inspect sling(s) for wear, tears, and loose stitching, bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately. Lifting the Patient: Warning. When elevated a few inches off the surface of the stationary object (wheelchair, commode, or bed) and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the hander bar. If any attachments are not properly in place, lower the patient back onto the stationary object (wheelchair, commode, or bed) and correct this problem. Adjustments for safety and comfort should be made before moving the patient. Prior to the start of this survey on 01/26/2026, the facility has taken the following actions to correct the noncompliance:On 10/27/2025, V12(CNA/Certified Nursing Assistant) received formal one on one training on mechanical lift transfers, sling functions, sit to stand transfers, and one person transfers.On 10/27/2025, a facility wide audit was done to inspect all mechanical lift pads for damage.On 10/26/2025 to 11/04/2025, all certified nursing assistants were in-serviced on the proper technique and transfer mechanics for the use of the mechanical lifts, and sit to stand transfers, with competency return demonstrations. Also, in-serviced on the inspection of the mechanical lift pads for damage.The Director of Nursing or designee to conduct random observations during different shifts of five residents three times a week for four weeks and monthly thereafter. Any issues or concerns identified were to be addressed/ corrected immediately. Audits started 10/27/2025 for four weeks and are ongoing monthly after the four weeks.The Administrator or designee to conduct random observations during different shifts of two laundry staff members three times a week for four weeks and monthly thereafter. Audits started 10/27/2025 for four weeks and are ongoing monthly after the four weeks.A QA meetings were held on 11/25/2025 and 01/20/2026 with the facility Medical Director, Facility Administrator, and Director of Nursing to review the plan of correction of 10/26/2025.