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	07/25/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review the facility failed to update a resident's (R1) care plan intervention post resident fall. This failure affected 1 of 3 residents reviewed for falls.Findings include: R1 has a diagnosis which includes but not limited to repeated falls and spinal stenosis. R1 has a Brief Interview for Mental Status (BIMS) dated 06/05/25 without a score of 10 which indicates that R1 has some cognitive impairments. During this survey R1 was able to answer surveyor questions appropriately. R1's progress note dated 06/11/25 at 7:40 pm, authored by V12 (Agency Licensed Practical Nurse/LPN) that documents, in part: Situation: Resident transferred to the local hospital per MD's (Medical Doctors) request following fall. No observable injuries noted per SN (Skilled Nurse) at this time other than redness on areas directly impacted from fall (sacral, right buttocks, lower central back.) Background: Resident fell in the hallway coming from dining area from standing position while pushing wheelchair to her room. Fall was unwitnessed. R1's progress note dated 06/11/25 at 6:59 pm, authored by V12 (Agency LPN) that documents, in part: Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Falls. R1's care plan dated 02/04/25 documents, in part: R1 is at risk for falls confusion gait/balance problems and incontinence but does not show interventions for R1's fall on 06/11/25. R1's hospital record dated 07/10/25 documents, in part: Care Coordination Update: . Per chart review fall on 07/10 and 06/11. The facility's document dated 02/01/25 to 07/23/25 and titled Incident by Incident Type shows that the facility was aware of R1 sustaining a fall on 03/27/25 and 07/10/25 at the facility. On 07/23/25 at 11:29 am, R1 stated that she has had four falls at the facility. R1 stated that R1's last fall was about two weeks ago when R1 was in the bathroom, standing at the bathroom sink washing her face and body. R1 explained that staff was in the bathroom when R1 fell but was not able to catch R1 before she fell. R1 further explained that R1 has been with and without staff when R1 has fallen at the facility. R1 was able to recall that R1 had a fall in June 2025 at the facility however R1 was not able to recall the exact dates of R1's falls at the facility. On 07/24/25 at 10:25 am Surveyor requested V12 (Agency LPN) contact information and was informed that V12 was an agency nurse, and that the facility was unable to obtain V12's contact information. On 07/24/25 at 11:47 am, V14 (Registered Nurse/RN, Restorative Nurse) stated that V2 (Director of Nursing/DON) and V14 collaborate to oversee the falls program at the facility. V14 explained that V14 conducts a fall investigation for a resident that sustains a fall at the facility as soon as the fall is reported. V14 further explained that after every fall, V14 will also update the residents care plan with a fall intervention(s). V14 stated that the residents fall is investigated, and a fall intervention is put into place for the resident to prevent the resident from having a fall reoccur. V14 also stated that if a resident's care plan is not updated with a fall intervention after the resident has sustained a fall, the resident can have a fall again and can become injured. V14 explained that she is familiar with R1 at the facility. When V14 was asked regarding R1's fall investigation post R1's fall on 06/11/25 and V14 stated, To be honest, I only knew about two falls that she (R1) had. Today I learned there was a third fall when I was looking through the progress notes and saw she had a fall. On 07/24/25 at 11:51 am, V2 (DON) stated that V2 and V14 (RN, Restorative Nurse) collaborate to oversee the falls program at the facility. V2 explained that V2 coordinates with V14 to make sure that after a resident sustains a fall the resident's physician and family has been notified as well as a risk management assessment has been conducted for residents who may have sustained an injury or suspected injury during a fall, so that V2 can report the injury or suspected injury to the local state agency. V2 further explained that V14 collects and reviews the fall investigation report, and V2 will discuss the appropriateness of the intervention that is put into place by V14 after a resident sustains a fall. V2 stated that a fall investigation is conducted, and a fall intervention is put into place after a resident sustains a fall in order to make sure the facility is preventing the resident from having another fall and/or to prevent the resident from sustaining an injury. When V2 was asked regarding R1's fall on 06/11/25, V2 stated that V2 was only aware of R1 having two falls at the facility. V2 then stated, R1's fall on 06/11/25 was a V12 (Agency Nurse LPN) that did not notify me or V14 regarding R1's fall. She (referring to V12) was a substandard nurse and is not able to return to the facility. The facility policy dated 11/21/17 titled Fall Prevention Program 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 . Guidelines: The Fall Prevention Program includes the following components: . Care plan incorporates: Identification of all risk/issue. Address each fall. Intervention

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review the facility failed to investigate a resident (R1's) fall. This failure affected 1 of 3 residents reviewed for fall accidents/incidents.Findings include: R1 has a diagnosis which includes but not limited to repeated falls and spinal stenosis. R1 has a Brief Interview for Mental Status (BIMS) dated 06/05/25 without a score of 10 which indicates that R1 has some cognitive impairments. During this survey R1 was able to answer Surveyors questions appropriately. R1's progress note dated 06/11/25 at 7:40 pm, authored by V12 (Agency Licensed Practical Nurse/LPN) that documents, in part: Situation: Resident transferred to the local hospital per MD's (Medical Doctors) request following fall. No observable injuries noted per SN (Skilled Nurse) at this time other than redness on areas directly impacted from fall (sacral, right buttocks, lower central back.) Background: Resident fell in the hallway coming from dining area from standing position while pushing wheelchair to her room. Fall was unwitnessed. R1's progress note dated 06/11/25 at 6:59 pm, authored by V12 (Agency LPN) that documents, in part: Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Falls.On 07/23/25 at 11:29 am, R1 stated that she has had four falls at the facility. R1 stated that R1's last fall was about two weeks ago when R1 was in the bathroom, standing at the bathroom sink washing her face and body. R1 explained that staff was in the bathroom when R1 fell but was not able to catch R1 before she fell. R1 further explained that R1 has been with and without staff when R1 has fallen at the facility. R1 was able to recall that R1 had a fall in June 2025 at the facility however R1 was not able to recall the exact dates of R1's falls at the facility.On 07/24/25 at 11:47 am, V14 (Registered Nurse/RN, Restorative Nurse) stated that V2 (Director of Nursing/DON) and V14 collaborate to oversee the falls program at the facility. V14 explained that V14 conducts a fall investigation for a resident that sustains a fall at the facility as soon as the fall is reported. V14 further explained that after every fall, V14 will also update the residents care plan with a fall intervention(s). V14 stated that the residents fall is investigated, and a fall intervention is put into place for the resident to prevent the resident from having a fall reoccur. V14 also stated that if a resident's care plan is not updated with a fall intervention after the resident has sustained a fall, the resident can have a fall again and can become injured. V14 explained that she is familiar with R1 at the facility. When V14 was asked regarding R1's fall investigation post R1's fall on 06/11/25 and V14 stated, To be honest, I only knew about two falls that she (R1) had. Today I learned there was a third fall when I was looking through the progress notes and saw she had a fall.On 07/24/25 at 11:51 am, V2 (DON) stated that V2 and V14 (RN, Restorative Nurse) collaborate to oversee the falls program at the facility. V2 explained that V2 coordinates with V14 to make sure that after a resident sustains a fall the resident's physician and family has been notified as well as a risk management assessment has been conducted for residents who may have sustained an injury or suspected injury during a fall, so that V2 can report the injury or suspected injury to the local state agency. V2 further explained that V14 collects and reviews the fall investigation report, and V2 will discuss the appropriateness of the intervention that is put into place by V14 after a resident sustains a fall. 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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 .Standards: A fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after an fall incident . Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determined possible safety interventions . Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan.