

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055475		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/19/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE WAUKEGAN				STREET ADDRESS, CITY, STATE, ZIP CODE 2222 AUDREY NIXON BOULEVARD , WAUKEGAN, Illinois, 60085			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation 25111213 / 2669888						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610 a)						
	300.2210 b)2)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.2210 Maintenance						
	b) Each facility shall:						
	2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.						
	These requirements are not met as evidenced by:						
	Based on observation, interview, and record review, the facility failed to ensure a light fixture was in safe operating order. This failure resulted in the light fixture falling from the ceiling, landing on the resident while in bed, and R1 sustaining a second						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 degree burn. This applies to 1 of 3 residents (R1) reviewed for safe physical environment in the sample of 3. Findings include: R1's electronic face sheet documents R1 has diagnoses that include peripheral vascular diseases, left leg amputee, and hypertension. R1's facility assessment, dated 10/3/25, show R1 has no cognitive impairment. R1's Emergency Department (ED note), dated 10/6/25, documents, "Patient presented from facility burned to right upper arm. EMS stated light fixture caught on fire and plastic pieces came down on patients' right arm second degree burn noted. Patient alert and denied shortness of breath said he was in his room when the light fixture above had a clot fire and melted plastic pieces dripped down his arm, patient complaining of pain in his right upper arm-skin: warm to touch, 14x 7 centimeter (cm) with blanching erythema as well as epidermal desquamation, the distal palmar surface of the left middle finger has mild blanching erythema. Diagnoses: second degree burns with deep and superficial partial thickness burn-right upper arm as well as superficial partial thickness burn of the palmar aspect of his distal left middle finger due to melted plastic without evidence of infection, tetanus updated in the ER patient was given pain med-improvement of pain." R1 was discharged with topical antibiotic ointment applied three times a day-TID. " On 11/18/25 at 10 AM, R1 was alert and pleasant lying in bed. A dressing was noted to his right upper arm. R1 stated, "That time when I got burned, I was eating my cereal for breakfast, all of a sudden the light fixture on the ceiling above me exploded, the plastic covering fell on me, it was so hot it burned me it hurt so bad (pointing to his right upper arm), my blankets, my hospital gown were on fire, I was yelling for help!" R1's left middle finger redness had subsided. V2 (Director of Nursing) removed R1's dressing. R1's right upper arm was still reddened with several small open areas with clear drainage noted. V2 said R1's right upper arm that was burned was being treated with antibiotic ointments covered with dry dressing. On 11/19/25 at 9:30 AM, V4 (Registered Nurse-RN) said she was R1's Nurse last 10/6/25. V4 (RN) said she was outside R1's room passing morning meds when she heard	S9999					

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S9999	Continued from page 2 R1 yelling for help. V4 said she went to R1, there was fire in the ceiling above him; there was fire noted on the side of his bed. V4 said she screamed, "help, fire! fire!" as she was pulling R1's bed away from the ceiling. V4 said V5 (Certified Nursing Assistant-CNA) came to help pull R1 away from the fire. 911 was called. R1 was sent to the ER. R1 came back to the facility with second degree burns. On 11/18/25 at 1:36 PM, V5 (CNA) said that day (10/6/25) he was collecting breakfast trays from rooms as breakfast was just finishing, when he heard loud screams coming from R1's room. V5 said he ran towards R1's room, the Nurse (V4) was already there pulling R1 in his bed for safety away from the ceiling. A ceiling tile fell on top of R1, smoke was noted in the ceiling, fire sparks were noted in R1's covers. R1 was shocked and confused. R1 was noted to have burned areas in his right upper arm. 911 was called. A fire extinguisher was used to spray the ceiling to stop the fire. On 11/18/25 at 11 AM, V7 (Maintenance Director) said it was around 8:30 in the morning on 10/6/25, a code red was initiated indicating a fire on the 4th floor. V7 said he hurriedly went to 4th floor, staff have extinguished the fire. At this time, the fire alarm had been activated, and Fire Department arrived (EMS). EMS cleared the code red. R1 was transported to the hospital via 911. V7 said investigation shows the cause of the fire was a light fixture in the ceiling. There was a loose contact that caused overheating and fire. The light fixture was still the original one years ago. V7 said prior to the incident, the preventive maintenance was just to go around looking for broken bulbs and replacing them. After this incident, (when R1 sustaining second degree burns) all the light fixtures have been checked. All light fixtures have been replaced with LED lights. V7 said an Electrician Company came to check the facility. An electrician report, dated 10/6/25, showed, "Called to the facility why a light fixture caught on fire. Noticed that the plastic covering on the LED T8 bulb was melted and the end of the lamp was burnt (sic). We walked through the other residence (sic) room and took note of lamps that were not working but did not notice any arcing or discoloration on any of the other light fixture." On 11/19/25 at 9:30 AM, V1 (Administrator) said all lights were now in good working order and continue to educate staff to report any defective light fixture. V1 also said a reportable was sent to the state agency.		S9999				

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S9999	Continued from page 3 The Facility Reported Incident sent to the state agency as final, dated 10/10/5, documents: "On 10/6/25 at 8:30 AM, code red was initiated indicating a fire, staff immediately responded to the 4th floor room 410 (R1's room) During the code, staff retrieved fire extinguisher and put out the small flame. 911 was notified, fire department responded cleared the code red... (R1) was transported to the local hospital. Initial root cause analysis showed the light fixture malfunction in (R1's) room, light fixture melted onto the bed of (R1). Ballast connection to the light bulb became too hot and sparked. All preventive maintenance was reviewed and note that there were no issues with any light bulb in the building, staff educated on what to do if observing a malfunctioning light fixture." The Facility Policy on Environmental Services, (undated) documents, to ensure that the facility is designed, equipped and maintained in accordance with all governing rules and regulations and standards. (B)	S9999					