**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE** ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) **Initial Comments** S 000 Annual Licensure and Certification Complaint Investigation: 22910003/IL154396 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies 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.

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

but not limited to, the presence of incipient or

Section 300.1010 Medical Care Policies

The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including.

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6005904 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE ELEVATE CARE COUNTRY CLUB HILL** COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Pursuant to subsection (a), general

Illinois Department of Public Health

nursing care shall include, at a minimum, the

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE** ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 following and shall be practiced on a 24-hour. seven-day-a-week basis: All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the nursing services of the facility, including: Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on interviews and record reviews, the facility failed to follow their Fall Prevention Program by not implementing appropriate fall interventions to provide necessary supervision for 1 (R357) of 4 residents reviewed for falls in a sample of 30. This failure resulted in R357 falling out of bed unwitnessed on 12/15/22 at

Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE** ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 approximately 4:30am and was found on the floor with a head laceration, went into cardiac arrest in the ambulance enroute to the hospital, arrived in the emergency room (ER) as a traumatic cardiac arrest, was found hypoxic with left sided atelectasis, and was pronounced expired at 7:57am with acute respiratory failure due to mucus plug with occlusion of trachea as the cause of death. Findings include: Areview of R357's clinical records revealed R357 was initially admitted in the facility on 10/06/22 and was re-admitted from an acute hospital on 12/07/22. R357's listed diagnoses are not limited to acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, dependence on respirator [ventilator] status, cognitive communication deficit, weakness, other lack of coordination, and bipolar disorder. R357's physician order sheet (POS) shows R357 was on high-risk psychotropic medication. Seroquel 100mg given at bedtime, R357's admission Minimum Data Set (MDS) with assessment reference date (ARD) of 10/13/22 shows R357 required extensive one staff assist in bed mobility and toileting. R357's "Fall Scale Evaluation" dated 10/06/22 shows R357 was at moderate risk for falling. R357's "Fall Scale Evaluation" dated 12/07/22 shows R357 was at low risk for falling. R357's comprehensive care plan that was initiated on 10/14/22 shows R357 "is at risk for fall R/T Deconditioning and impaired gait" with only these interventions that read in part: "Keep call light and desired personal items within reach" and "Maintain bed in lowest

position".

Ilinois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE ELEVATE CARE COUNTRY CLUB HILL** COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 R357's Fall incident report dated 12/15/22 at 4:30am documented by V47 (Agency Nurse) reads in part, "Resident observed laying on right side of face near trach accessory tubing. Pool of dark red blood noted under resident. Resident laying with head near right side of the wall next to bed. Feet near foot of bed. Bed in lowest position. Resident opens eyes to verbal command. Resident unable to state what happened. Periods of drowsiness noted. 4 cm laceration noted to fore head." R357's progress note documented by V42 (Respiratory Therapist) dated 12/15/22 at 7:28am reads, "Around 4:40am called to room by nurse. Observed patient/pt on floor, vent alarmed. Both nurses & RT in room, Trach checked, it was patent and tubing intact. Nurse took vitals, and recorded SPO2 87% and began bagging pt with 100% oxygen. She had altered mental status. 911 was called, pt out to hospital." Facility's fall incident investigation on R357 documents in part: A witness statement from V61 (Certified Nursing Assistant/CNA) documents R357 on 12/14/22 was observed getting back into bed without assistance from using bed side commode. A witness statement from V45 (Certified Nursing Assistant) dated 12/15/22 documents that R357 was last seen at 2:30am while rounding and R357 was observed getting back into bed from using the bedside commode unassisted. A witness statement from V47 dated 12/15/22 documents at 4:30am V47 noticed R357's call light/ventilator alarm were sounding. V47 went into R357's room and observed R357 on the right side of R357's bed. A review of R357's Emergency Department (ED) triage notes dated 12/15/22 at 5:44am reads in part, "Pt came

Illi nois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION ın PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 from nursing home due to fall. Pt has a left sided facial laceration. Pt lost pulse while in ambulance. Emergency Medical Services/ EMS began CPR (no epis given). Trauma at bedside. Pt has a trach and is chronically vented." Areview of R357's ED provider notes dated 12/15/22 at 9:06am revealed R357 was brought in as a traumatic arrest and initially managed by the trauma team. R357 reportedly fell out of bed at the nursing home and was found on the floor with a head laceration. R357 went into cardiac arrest in the ambulance enroute to the hospital. R357 arrived as a traumatic cardiac arrest and was found hypoxic with left sided atelectasis. R357 was pronounced dead at 7:57am. Areview of R357's death certificate dated 12/15/22 shows acute respiratory failure due to mucus plug with occlusion of trachea as the cause of death. On 1/24/23 at 11:44am, V10 (Registered Nurse 2nd Floor Manager) was interviewed and stated that R357 was high risk for falling. V10 stated that R357 used the bedside commode for toileting and needed one staff assistance. V10 stated that at times R357 would get up without assistance and forgets to call for help when needed. V10 stated that R357 had no bed alarm. At 12:02 pm, V38 (Certified Nursing Assistant) was interviewed and stated that V38 had taken care of R357 while in the facility. V38 stated that R357 gets confused at times and would get up by herself but was not supposed to. V38 stated that R357 would sometimes forget how to use the call light. V38 stated that R357 was using a bedside commode for toileting needs and was doing it by herself but was not supposed to because it was

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005904 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE** ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY S9999 Continued From page 6 S9999 not safe for R357, V38 stated R357 needed assistance with incontinence care. At 12:13pm, V9 (Respiratory Therapist) was interviewed and stated that R357 was on a full support ventilator and was "very, very anxious". V9 stated that respiratory therapists (RTs) and the nurses should be monitoring the residents' ventilators. V9 stated that if the ventilators are not working properly, it would alarm. On 1/25/23 at 7:16am, a phone interview conducted with V42 (Respiratory Therapist). V42 stated that V42 was the RT assigned to R357 on 12/15/22 until 7:00am. V42 stated that R357 did not sleep that night. V42 stated that at around 4:00am, a nurse called V42's attention to R357's room because R357 fell from the bed. V42 stated, "I saw [R357] was bleeding on [R357] forehead. On [R357] middle forehead. [R357] was lying on [R357] right side on the floor by [R357's] bed. I immediately checked the vent. The tubing was not disconnected. The nurse turned [R357] and cleaned the [R357]. I checked the vent it was working properly and no other issues. [R357] right hand was lying over the trach tubing. I removed the hand from the tubing. [R357's] saturation was near about 94%. Nurse called 911 right away within 10 mins they came. [R357] was okay when 911 picked [R357] up. [R357's] heart rate was up but [R357's] saturation was 94-96%." At 11:18am, a phone interview conducted with V45 (Certified Nursing Assistant) and stated that V45 was the CNA in-charge of R357 from 12/14/22 night shift until 12/15/22 in the morning. V45 stated that V45 was on break when R357 fell out of bed. V45 stated that V45 went on break from 2:30am and came back at 5:00am. V45

Illinois Department of Public Health

stated R357 needed limited assistance from staff

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING: \_ COMPLETED B. WING IL6005904 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE** ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478 (X4)ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 7 S9999 to use the bedside commode. V45 stated that R357 was on her (R357) phone all night that night. V45 stated R357 used the call light if needed but sometimes forgets and would get up by herself. At 11:36am, V2 (Director of Nursing) was interviewed and stated that fall risk assessment are done on resident's upon admission and after a fall. V2 stated that fall a care plan is initiated on admission and updated if there is a fall and based on the MDS calendar, V2 stated that fall interventions should be based on the nursing assessment and the resident's history. V2 stated that R357 came back from the hospital on 12/7/22 and R357's fall care plan was not revised. V2 stated that an appropriate fall intervention for R357 would be to remind R357 to call for assistance unless R357 was strong enough as far as therapy goes, but these were not indicated in R357's fall care plan. V2 stated, "As far as I'm aware the staff did not let [R357] use the commode on her [R357] own but [R357] was observed not calling for help and staff would re-direct every time when they see [R357] transferring on her [R357] own." Surveyor asked V2 to provide documentation indicating education and re-direction were provided to R357, V2 stated that the education and re-direction were done verbally and would not be documented. On 1/26/23 at 11:49am, interviewed V33 (Staffing Coordinator) and stated that nursing staff can go on break for 30 minutes and a 15-minute quick break but not at the same time. V33 stated that more than an hour break is not acceptable. At 2:11pm, a phone interview conducted with V59 (Nurse Practitioner), V59 stated V59 took care of R357 while in the facility. V59 stated that R357

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6005904 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478** (X4)ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 8 S9999 had tracheostomy and was too anxious. V59 stated that R357 had the tendency to not call for help when needed. V59 stated that R357 had a decline with R357's debility and needed more assistance. V59 stated that R357 fell, was sent out to the hospital, and expired. V59 stated V59 does not know R357's cause of death. Surveyor asked V59 that if a resident is on full support ventilator, fell with head trauma and wound development could that be contributory factors for a resident to have acute respiratory failure. V59 answered, "Yes definitely." At 3:33pm, V50 (MDS/Care Plan Coordinator) was interviewed and stated that fall risk assessments are done first upon admission and the care plan should be implemented based of that, if the resident has history of fall, on psychotropic medications, and based on what type of assistance the resident needs. V50 stated that the resident's comprehensive care plan should be completed up to 21 days from admission. V50 stated that if a resident is at risk for falling and has the tendency to get up without assistance and is not supposed to, that problem should be included in the fall care plan. V50 stated that the care plan interventions should include based on the resident's risk factors that have been identified based on resident's assessment, staff observations, fall assessment, review of records, and resident and family

Illinois Department of Public Health

interviews. V50 stated that the care plan should address what the staff assess from the resident because the purpose of the care plan is to guide the plan of care of the resident. V50 stated that the care plan is also used for communication so

preferences, and concerns of the resident are. V50 stated that care plan interventions should be implemented based on what the staff establish

the staff would know what the needs.

Illi nois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE **ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PRFFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 9 S9999 from the resident, and it would be specific based of whatever the concerns of the resident are. V50 stated, "If it's a fall care plan the interventions should be based on whatever the problem of the resident. It should include something that we know of about the patient." V50 stated that if the care plan is incomplete, the staff might not be able to adequately decrease the risk of the resident from falling and the staff won't be able to know the plan of care of the resident. V50 further stated that the resident's care plan should also be reviewed upon re-admission. Surveyor called V47 and left messages on these dates and times but to no avail: 1/25/23 at 7:12pm, 11:28am; and 1/26/23 at 7:40am and 3:20pm. V47 was the agency nurse in charge for R357 when the fall incident happened. The facility's policy titled; "Fall Prevention Program" revised on 11/21/17 reads 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. Standards: "Safety interventions will be implemented for each resident identified at risk. The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED IL6005904 B. WING 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **18200 SOUTH CICERO AVENUE ELEVATE CARE COUNTRY CLUB HILL COUNTRY CLUB HILLS, IL 60478** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 S9999 Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care. The facility's policy titled; "Comprehensive Care Plan" revised on 11/17/17 reads in part: Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (A)

Illinois Department of Public Health STATE FORM