Illinois Department of Public Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
IL6005904		B. WING		C 12/12/2024			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		18200 SO	UTH CICERO	DAVENUE			
ELEVAII	E CARE COUNTRY CI	COUNTRY	( CLUB HILL	.S, IL 60478			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	ΓE	
S 000	Initial Comments		S 000				
	Complaint Investiga 2499717/IL181657	ation:					
S9999	Final Observations		S9999				
	Statement of Licens 300.610a) 300.1210b) 300.1210d)3)						
		esident Care Policies					
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shal	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed					
	Section 300.1210 General Requirements for Nursing and Personal Care						
	care and services t practicable physica well-being of the re each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re	shall provide the necessary o attain or maintain the highest l, mental, and psychological sident, in accordance with nprehensive resident care l properly supervised nursing care shall be provided to each e total nursing and personal esident.					
ABORATOR	tment of Public Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE 12/31/24	.4	
STATE FOR	M		6899 Q	OZW11	If continuation sheet 1	of 7	

If continuation sheet 1 of 7

Illinois Department of Public Health						5
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
IL6005904		B. WING		C 12/12/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELEVATI	E CARE COUNTRY CL		UTH CICERO ( CLUB HILL			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	:
S9999	Continued From pa	ge 1	S9999			
	nursing care shall in following and shall is seven-day-a-week 3) Objective of resident's condition emotional changes determining care re- further medical eva made by nursing sta- resident's medical re- These Regulations Based on interview failed to transcribe care medications for hospice care service (R1) of five resident orders and resulted	bservations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the				
	with diagnoses that malignant colon car electronic health re- 10/28/24 indicate R oncology appointme a diagnosis of adult hospital, and due to health, R1's healtho admit to hospice se facility. Consent for in the hospital on 17	dmitted to the facility 1/25/23 included but are not limited to ncer. According to R1's cord, progress notes of 1 went to an outpatient ent and was hospitalized with failure to thrive. While in the 0 R1's sudden decline in care proxy elected for R1 to prvices upon returning to the hospice services was signed 1/2/24.				

## PRINTED: 01/30/2025 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005904				CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _	A. BUILDING:		С
		IL6005904	B. WING		12/12/2024	
IAME OF I	AME OF PROVIDER OR SUPPLIER STREET AL			TATE, ZIP CODE		
LEVATI	E CARE COUNTRY CI					
				PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	SUMMARY STATEMENT OF DEFICIENCIES         COUNTRY           X         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

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Illinois Department of Public Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         IL6005904		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			C 12/12/2024	
IAME OF PROVIDER OR SUPPLIER STREET A			DDRESS, CITY, ST	TATE, ZIP CODE		
LEVATE	E CARE COUNTRY CI		OUTH CICERO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 3	S9999			
	for fever and pain. I Nurse) and facility r orders were review At the time of this s Order Sheet for No	cetaminophen suppositories Hospice RN (Registered hurse V7 LPN signed that ed and received. urvey, review of Physician's vember 2024 did not include the hospice orders for				
	caring for R1. On 1 R1 was transferred weekend, and the ( assess and admit F 11/4/24. While the r medication and oth the facility nurse on nurse was identified and signature on th the hospice compa medications from a the medications use time the admitting r medications are av- admission. V6 also manifest that listed medications from th medications deliver Morphine Sulfate 20 solution received by Hospice Comprehe the admitting hospid 1:50pm, and "time of					
	Hospice Support Se chaplain included a During the Chaplair	noted visiting R1 on 11/5/24. ervices Log written by the care plan open for pain. n visit R1 was noted to exhibit reports no, grimacing with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005904		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		B. WING		12/	12/2024	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ELEVATE	E CARE COUNTRY CL		OUTH CICERO			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	ge 4	S9999			
	anticipation."					
	5:32am stated "[R1 breath while lying fl of bed elevated Vita via [nasal cannula]. this time, will contin	ess Note dated 11/7/24 at ] observed with shortness of at, resident repositioned, head al signs taken, [oxygen] given [R1] appears comfortable at ue to monitor. Resident hospice services. will continue				
	Nursing) stated, the concern related to F available, however nurse on duty with of the nurse (V10 LPN to call hospice direct didn't have any orded documented in the stated they didn't kr available, and I didr in the [electronic he say, at the time of the assessment of the care, facility nurses new orders provide primary provider an the Physician Order	53am V2 DON (Director of ey were not aware of any R1's pain medication not being remembered helping the orders on 11/7/24. V2 stated I) was fairly new and we had otly for the orders because R1 ers for the morphine electronic health record. V2 how if the medication was n't ask but I did put the orders ealth record]. V2 went on to he hospice nurse's residents admitting to hospice are expected to review any d by hospice relay them to the d transcribe the orders onto r Sheet. Nurses are then progress note indicating this				
	confirmed V7 LPN a working R1's unit th On 12/12/24 at 3:33 was short one nursivery busy. V7 recal	hedules were reviewed and and V8 LPN as the nurses the 7am-3pm shift on 11/4/24. Bpm V7 LPN stated the unit that day and it was likely led taking care of R1 on recall receiving hospice				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
	IL6005904		B. WING		12/	12/2024
NAME OF I	AME OF PROVIDER OR SUPPLIER STREET AD			TATE, ZIP CODE		
		18200 SC	OUTH CICERO	AVENUE		
ELEVAII	E CARE COUNTRY CL	LOB HILL COUNTR	Y CLUB HILLS	S, IL 60478		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLET DATE
1/10		,	1/10	DEFICIENC		
S9999	Continued From pa	nge 5	S9999			
00000	Continued From pa	ige o	00000			
	0 40/40/04 -+ 40/					
		07pm V8 LPN stated they king the unit that morning and				
		ring medications for R1.				
	The Physician Orde	er Sheet indicated three orders	;			
		documented by V2 on 11/7/24 at 11:03 for				
		Morphine Sulfate: Morphine Sulfate (Concentrate)				
		(milligram/milliliter) Give 5 mg				
	by mouth every 2 hours as needed for moderated					
	Pain give 5mg; Morphine Sulfate (Concentrate)					
	Solution 20 mg/ml Give 10 mg by mouth every 2 hours as needed for Severe Pain Give					
		hine Sulfate (Concentrate)				
		Give 5 mg by mouth every 1				
		or dyspnea/ air hunger/				
		/ respiratory rate give 5mg.				
	Policy for Transcrin	tion of Physician Orders no				
		in part: Purpose: 1. To				
		dure by transcribing new				
		. To document and give clear				
		ician orders have been				
		on taken. Admission Protocol				
		spital Stay: 1. Transcription of				
		Carefully, review transfer				
		ge summary from the hospital				
		rd from another health care sed nurse should notify the				
		sident's admission, clinical				
		igs, review and clarify transfer				
		s orders, as applicable. C.				
		entered in the Physician Order	-			
		eck that all orders were				
		D. After physician verification,				
		completes a progress note				
		ysician is aware of the				
		the orders were verified. 6.				
		atment orders are to be				
	transcribed in the p	hysician order tab of the				

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ELEVATI	E CARE COUNTRY CI			RO AVENUE LS, IL 60478		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	Ē
S9999	electronic medical r understandable (wi the approved abbre who are responsible administrations. Hospice Services A facility signed 11/30 provider] shall also pharmaceuticals, m supplies relating to terminal illness as m Resident Hospice F to be provided by N Board. 1. Nursing F and Board" service services to each Re nursing Facility's re furnish 24-hour roo the personal care a have been provided at the same level of care was elected. S	record. Directions must be thout abbreviations other than eviations) by all staff members e for medication and treatment agreement contract with the 0/22 states in part "[hospice provide all prescription drugs, nedical equipment and a resident Hospice Patient's may be specified in such Patient' Plan of Care. Services lursing Facility: A. Room and facility shall provide "Room s in the form of personal care esident Hospice Patient. It is sponsibility to continue to m and board care, meeting and nursing needs that would d by the primary giver at home f care provided before hospice Such Room and Board de but not be limited to such ministration of medication as	S9999			
STATE FOR			6899	9QZW11	If continuation sheet 7	of 7