

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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			12/09/2025	
	Annual Licensure and Complaint 25910337/2649180 Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	(1 of 4)						
	300.690 a)						
	300.690 b)						
	300.690 c)						
	300.1210 a)						
	300.1210 b)						
	300.1210 c)						
	300.1210 d) 6)						
	Section 300.690 Incidents and Accidents						
	a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.						
	b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.						
	c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 1 pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care a) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 2 accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to notify the Regional Office within the required 24-hour timeframe after a serious injury for one resident (R18) reviewed for falls; and failed to provide adequate supervision to prevent a fall of one resident (R18), who was assessed at risk for fall and had a documented history of prior falls. As a result, R18 fell and sustained a head injury with a laceration requiring medical treatment, including closure of the laceration with Dermabond, and required R18 to be sent to the hospital for evaluation and treatment. Findings include: R18's face sheet documents diagnoses that include but are not limited to symptoms and signs involving cognitive functions and awareness, weakness, psychotic disorder with delusions due to known physiological condition, dementia, and visual loss. R18's BIMS (brief interview mental status), dated 11/11/25, documents a score of 3 which indicates R18's cognition is severely impaired. R18's MDS (minimum data set) section GG, dated 11/08/25, documents, in part, that R18 requires partial/moderate assistance for sit to lying, lying to sitting on side of bed, and sit to stand. R18's progress note, dated 10/30/25 at 8:38am, per V13 (Licensed Practical Nurse/LPN) documents, in part, "(R18) sent to hosp. (hospital)." R18's progress note, dated 10/30/25 at 12:04pm, per V50 (Nurse Practitioner) documents, in part, "Patient (R18) was evaluated in the emergency department after an unwitnessed fall. Continued monitoring of facial laceration and fall prevention measures are recommended." R18's progress note, dated 10/30/25 at 12:50pm, per V24 (Wound Care Director) documents, in part, "Resident had fall during shift. Resident noted with laceration to right eyebrow upon assessment. Site cleansed with nss (normal saline) pat dry and Dermabond applied and steri strips."			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 3 R18's Hospital records, dated 10/30/25, documents, in part, "Patient (R18) is a 71-year-old male with past medical history of prior CVA (cerebrovascular accident) on Plavix, dementia, who presents from his nursing home via EMS (emergency medical services) after an unwitnessed fall. Patient (R18) reportedly fell forward out of his wheelchair. Unknown whether patient had any loss of consciousness. Patient (R18) is on Plavix for hx. (history) of stroke. Right eyebrow laceration. This was an unwitnessed fall, and he (R18) is on Plavix, will obtain CTs (computed tomography) of the head and cervical spine at this time. CT of the head and cervical spine were performed. Discharge: Do not attempt to get out of bed or your wheelchair without assistance." R18's "Post Fall Observation," dated 10/30/2025, documents, in part, "location: lounge or day room; witnessed: no; He (R18) tried to walk; is there evidence of head injury: yes; laceration approximately 1 1/2 in. right upper eyelid." R18's "Post Fall Observations" show that R18 fell on 1/21/25, 4/22/25, 10/30/25, and 11/09/25. R18 experienced four falls within a ten-month period, including a subsequent fall occurring only ten days after a prior fall that resulted in a serious injury. On 11/19/25 at 11:07am, R18 said, "I (R18) fell many times. I (R18) don't know if I (R18) was reaching for something or what when I (R18) fell last month (10/30/25) out my chair. You listen to me (R18). I (R18) don't remember, all I (R18) know is it (the fall) hurt. Are you hearing me (R18)?" R18's "Morse Fall Scall Evaluation," dated 6/16/25 (most recent prior to 10/30/25 fall), documents a score of 75 which indicates R18 is at high risk for falling and documents, in part, "Gait: Impaired: difficulty rising from chair, uses chair arms to get up, bounces to rise; keeps head down when walking, watches the ground; grasps furniture, person or aid when ambulating. Cannot walk unassisted. Weak: stooped but able to lift head without losing balance; steps are short, resident may shuffle." R18's gait assessment shows a clear need for continuous supervision to prevent falls. R18 is unable to walk independently. R18 demonstrates impaired mobility, including difficulty rising from a chair, dependence on armrests to stand, and "bouncing" motions when attempting to rise. During ambulation, R18 keeps R18's head down, looking at the ground, and requires support by grasping furniture, another person, or an assistive device.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 4 R18's care plan, dated 6/29/2023, documents, in part, "(R18) is at risk for fall r/t (related to) deconditioning and weakness associated with neurocognitive impairment, dementia, and acute and chronic loss of vision, recent history of falls, spinal stenosis, neuropathy, s/p (status post) acute CVA (cerebrovascular accident), history of convulsions," with a desired outcome that documents, in part, "(R18) will be free from injury related to falls," with interventions, date initiated 5/19/23, "Falling Leaf Program." R18's care plan, dated 3/20/24, documents, in part, "(R18) presents with a self-care deficit due to inability to perform activities of daily living independently. Alert and oriented x2 w/periods of forgetfulness. Presents with new CVA. ROM (range of motion) with overall generalized weakness. Feeds self w/assist. Requires staff assist x1 with bathing, grooming, dressing, toileting, bed mobility, transfers, and ambulation. Stands/pivots. requires w/c (wheelchair) for mobility. propels w/staff assist,' with interventions that documents, in part, "provide assistance with care." R18's care plan, date 7/09/2025, documents, in part, "(R18) has potential for hemorrhage/bruising due to antiplatelet therapy r/t (related to) history of cardiovascular disease including HTN (hypertension), HLD (hyperlipidemia), and carotid stenosis, hx. (history) CVA (cerebrovascular accident), failed ASA (aspirin) therapy." R18's physician order, ordered date 6/16/25, documents, in part, "Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time a day for Stroke prevention." R18's physician order, ordered date 10/30/25 with a created date of 11/18/25 (showing the order was placed 20 days after R18 received the Dermabond, during the facility's annual survey), documents, in part, "Dermabond Advanced Topical Skin Adhesive application: apply to the affected area one time only for laceration to right eye lid for 1 Day." On 11/18/25 at 9:30 am, V2 (Director of Nursing/DON) said, "A report (IDPH Incident Report) wasn't done for that fall (R18's fall on 10/30/25) because it (fall) wasn't a serious injury. If the fall caused like sutures or a fracture we (facility) we do a report (IDPH Incident Report).		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 5 On 11/19/25 at 9:59am, V1 (Administrator) said, "I (V1) think that since Dermabond was used and not sutures does not make it a serious injury. We (facility) do report serious injuries to you (IDPH). V1 affirmed that the staff should not have left R18 in "that room" unsupervised. On 11/19/25 at 10:02am, V2 (Director of Nursing/DON) said, "It's (Dermabond) considered first aid. Not a serious injury. His (R18) last fall (11/09/25) R18 was in bed sleeping when R18 fell. Interventions in place to prevent R18 from falling are rounding, move closer (R18) to nurses' station, offer toileting. R18 was in the day room (10/30/25 when R18 fell). V44 (Certified Nursing Assistant/CNA) had just stepped away, was gone 15 to 20 seconds. No, she (V44) wasn't supposed to leave R18; for supervision reasons." On 11/19/25 at 10:35 am, V44 (Certified Nursing Assistant/CNA) said, "Yes, I (V44) worked when R18 fell on (10/30/25). He (R18) was actually my resident that day. He (R18) was one of my "get ups." I (V44) wheeled him into the tv room. Another resident, can't remember his name for life of me, wanted graham crackers. The resident was very loud about it and upsetting the other residents. No one was around. I (V44) ran over to the container. It (container) was at the nurse's station. The nurse's station is a big rectangle to the right about 15 to 20 feet. Gonna be honest, it (graham crackers) was kinda towards the middle on the countertop. My (V44) back was to R18. I'm (V44) gonna be honest. I (V44) ran over, can't even say about 20 seconds I (V44) was gone. Turned back and R18 was on the floor. I'm (V44) thinking he was asleep when I (V44) ran to grab the graham crackers." When asked if R18 should have been left unsupervised, V44 replied, "No, and that's the thing. R18 shouldn't have been unsupervised not even a second. The other residents were screaming and everyone screaming and getting agitated. We (V44 and residents) were watching WGN. The guy was crying, so I (V44) was like let me just get him a snack. Would I (V44) have normally done that...No. In hindsight I (V44) should have let everyone grumble." On 11/19/25 at 11:00am, V13 (Licensed Practical Nurse/LPN) said, "Yeah, I (V13) was there when R18 fell that day (10/30/25). I (V13) don't know much because I (V13) didn't see it (R18 falling). They (staff) said no one seen R18 fall (unwitnessed). I (V13) can't remember who told me (V13). R18 said he slipped. I (V13) assessed R18, put R18 back in the chair, and sent R18 out (to the hospital). R18 had a laceration on his (R18) head."		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 6 On 11/19/25 at 12:51pm, V31 (Nurse Practitioner) said, "Dermabond, not anyone can give it (Dermabond). I (V31) believe Dermabond is considered a medication. I'm (V31) not too familiar with it (Dermabond). After a fall, if there's physical evidence to the head like a laceration I (V31) would consider it a serious injury. Any head trauma, especially on a blood thinner, I'm (V31) very careful. If you have a laceration then you harmed yourself." On 11/19/25 at 1:07pm V31 (Nurse Practitioner) said, Dermabond is by prescription so a CNA (certified nursing assistant) wouldn't use it. Since it's prescription technically it's (Dermabond) medical treatment, not first aid." On 11/19/25 at 1:15pm, V50 (Nurse Practitioner) said, "I (V50) know R18. What I (V50) understand is they (staff) are versed in in-services for Dermabond. R18 was sent out for a CT (computed tomography) scan for fall (10/30/25). Dermabond, they (staff) have to be trained and signed off on it. I (V50) believe Dermabond to be a medical treatment. The fall probably caused harm. R18 is not steady on his (R18) feet. Yes, he (R18) requires supervision and assistance." On 11/19/25 at 2:12pm, V24 (Wound Care Director) said, "Yes, I (V24) applied the Dermabond, after the fall (R18's fall on 10/30/25). I (V24) was in-serviced (on the application of Dermabond). The nurses can apply Dermabond once in-serviced not the CNAs (certified nursing assistants). It's (Dermabond) a medication, and nurses need to be trained. It's (Dermabond) a medical treatment not first aid." R18's MDS (minimum data set), gait evaluations, fall history, fall assessments, and overall functional status clearly indicated R18 is at high risk for falls. These documented findings show R18's needs to be provided appropriate supervision to ensure safety. The lack of supervision resulted in R18 falling and sustaining a head laceration requiring medical treatment and hospital evaluation. Record review of facility's Inservice titled, "Laceration Repair: Dermabond Usage," dated 5/9/25; 7/23/25; and 9/30/25, documents required training for nurses to administer Dermabond. Record review of facility policy titled, "Falling Leaf Program," date 5/18/23, documents, in part, "The Falling Leaf Program may be voluntarily implemented at the discretion of the facility as an additional intervention for the reduction of falls. With this program, the facility interdisciplinary team targets a select of residents who are at risk for falls: Criteria			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 7 for choosing residents on the falling leaf program may include: Impaired safety awareness that has contributed to a fall; Residents with multiple falls in a 6-month time frame; Residents who have sustained serious injury; Acute decline or significant change of condition. The staff will visually check all residents on the program as determined by the team to: Ensure safety, Assist with care needs, and Prevent unsafe self-transfers." Record review of facility policy titled, "Fall Prevention Program," dated 11/21/17, documents, in part, "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. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained." Record review of facility policy titled, "Traumatic Skin Injury – Repair of a Laceration with an Adhesive Glue," 3/21/2024, To establish guidelines for assessing, monitoring, treating, and documenting the presence of skin alteration after an event and assuring interventions are implemented. Notify the physician/nurse practitioner and obtain a physician order for Dermabond Advanced Topical Skin Adhesive application to the affected area. Record review of facility policy titled, "Abuse Prevention and Reporting – Illinois," dated 1/22/19, documents, in part, "or resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts." Record review of facility policy titled, "Resident Rights," dated 1/04/2019, documents, in part, "To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. Record review of The Medicaid / NCCI (National Correct Coding Initiative) manual Chapter 5, revised date 1/01/2021, documents, in part, "Facilities may report wound closure using sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT (current procedural terminology) code in the "Repair (Closure)" section of			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 8 the "CPT Manual." This billing treatment shows that tissue adhesive closure is a medical procedure, not simple first aid. Record review of scholarly article from the U.S. Food and Drug Administration (https://www.fda.gov/medical-devices/guidance-documents/-medical-devices-and-radiation-emitting-products/tissue-adhesive-topical-approximation-skin-class-ii-special-controls-guidance-industry-and-fda-staff), document issued May 30, 2008, documents, in part, that The FDA (Federal Drug Administration) classifies "tissue adhesive for topical approximation of skin" as a Class II medical device. That indicates it's regulated as a medical device, not first aid. (B) (2 of 4) 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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 300.1210 General Requirements for Nursing and Personal Care 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.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 9 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary assistance for one dependent resident (R149) in accordance with care plan by failing to complete weekly shower/skin assessment as ordered. This failure affected one (R149) of six residents reviewed for Activities of Daily Living (ADL) care. R149 developed a hematoma to her right great toe at the facility, complaint of pain where it was noted R149's wound was infected, and an x-ray revealed a fracture to the right great toe. R149 was treated with oral antibiotics for seven days. Findings include: R149 is a 58-year-old female who has resided at the facility since 8/28/2025, past medical history includes, but not limited to hypertensive heart disease, other dysphagia, other reduced mobility, type 2 diabetes, anemia, hemiplegia, and hemiparesis following cerebral infarction affecting the right dominant side, etc. On 11/17/2025 at 10:30AM, R149 was in her bed, awake and alert but could not answer any questions, resident was able to nod yes and no to some questions. The nurse was outside the door preparing medication for resident, surveyor requested her assistance to assess resident's right great toe, which was noted with no dressing, dry and with some whitish discoloration close to the nail bed. Surveyor asked resident if she still gets dressing to her toe and she shook her head no. Wound care note dated 10/1/2025 documented a facility acquired hematoma to right great toe measuring 2.50 X 2.0 X unknown (L X W X D). Area 5.00cm, volume unknown. Tissue type- blood filled blisters 100%.			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 10 R149 was assessed as being dependent on staff for all activities of daily living (ADL) needs and always incontinent of bowel and bladder, Behavior assessment indicated that resident does not exhibit any behaviors. Active physician order documented the following: Right great toe: cleanse with normal saline, pat dry and paint with betadine and cover with dry dressing daily and as needed for wound care. Weekly showers/skin assessment, acknowledgement of shower and skin assessment completed. If new skin issue, notify physician, notify family and complete skin assessment form. Care plan initiated 10/1/2025 documented that resident has arterial wound to right great toe, is at risk for delayed wound healing and is at risk for further alteration in skin integrity related to anemia, diabetes, hypertension, and peripheral arterial disease. Interventions include monitor skin during care and report changes, ongoing assessment of wound to evaluate signs of deterioration or improvement, treatment as ordered by physician, etc. Urgent care record dated 10/25/2025, history of present illness documented in part: 58-year-old female parented(sic) with right great toe injury discovered 25 days ago by family when they removed resident's socks. Currently patient reports pain to right great toe at the site of injury, pain is worse with touch. X-ray of foot 3 or more view indicated under impression of acute nondisplaced intra- articular fracture of the distal phalanx of the right toe. Diagnosis was listed as cellulitis of right toe, nondisplaced fracture of distal phalanx of right toe, type 2 diabetes. Medication orders: prescribed clindamycin HCL300mg capsule, take 1 capsule by mouth every 6 hours for seven days. Shower sheets for the months of September, October and November indicated that R149 was not receiving showers as scheduled, occasional bed baths, no documented skin assessment and marked mostly as refused. On 11/19/2025 at 12:59PM, V49, Certified Nursing Assistant (CNA) said that she does not have any issues with resident, she works with her on day shift and always assist her with dressing up and brushing her teeth. Resident is usually set up in the bathroom by the sink, and she brushes her teeth by herself. Resident does not refuse ADL care as far as V49 is concerned, she is always pleasant.			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 11 On 11/18/2025 at 3:05PM, V24 (Wound Care Coordinator) said, nurses are supposed to sign off the skin assessment section of the shower sheet after the CNA finishes the shower if the resident lets them. V24 was asked if the nurses should document resident's refusal in the progress note and she said that she is not sure, that will be the question for the nurses. On 11/19/2025 at 2:15PM, V24 was asked about R149 wound to her great toe. V24 said, resident was being treated with betadine and the wound was being assessed daily by wound care, and they did not notice any signs of infection. V24 added that she was not aware that resident's toe was infected, nor aware of the antibiotic treatment or that she had a fracture. On 11/19/2025 at 9:05AM, V2, Director of Nursing (DON) said, resident had a bump on her toe which started after family gave her a shower and told staff that they accidentally bumped resident's toe on her wheelchair. V2 said that the wound care doctor saw the resident and she was getting treatment for it. V2 added that R149 always refuse ADL care. Surveyor asked V2 if that was care planned, and she said that she was not sure. On 10/25/2025, resident's daughter came in, showered the resident, and dressed the resident herself, took the resident out on pass without informing anyone in the facility. While on pass, the daughter took resident to urgent care and they prescribed antibiotics for her, they also did an x-ray that showed a fracture to her right great toe, V2 does not know that resident's toe was infected, or how resident got the fracture. On 11/10/2025 at 12:15PM, V1 (Administrator) said that she investigated and reported resident's injury as an injury of unknown origin, but it was not unsubstantiated because resident did not complain of pain before the family took her out on pass. The injury started as a redness which occurred after family gave resident a shower and accidentally bumped her feet on her wheelchair V1 said that the family reported the incident to the nurse. On 11/19/2025 at 12:02PM, V51 (LPN) said that she worked 3 to 11pm shift on 10/25/2025, R149 was out on pass at the beginning of her shift. The daughter came to the nursing station later that evening and handed her a bottle of medication, stating that R149 has an infection to her toe and also has a fracture. V51 said that family usually gives resident a shower and one day, the daughter told V51 that she accidentally bumped resident's toe on her wheelchair, that's how she got the injury. Surveyor asked V51 if she documented the		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 12 reported incident by the family and she said no. V51 then changed her story stating that the family did not report that to her, but she just assumed that since they always give her a shower, that must have been the cause of the injury. V51 added that she is not sure how the resident sustained the fracture and was not aware that her toe was infected until the daughter came back from urgent care with the antibiotic. Bathing-shower and tub bath policy dated 1/31/2018 documented its purpose as to ensure resident's cleanliness to maintain proper hygiene and dignity. Guideline- a shower, tub bath or bed/ sponge bath will be offered according to resident's preference two times per week, or according to resident's preferred frequency and as needed or requested. Document bathing and assistance provided in the electronic health record, including pertinent observations.(B) (3 of 4) 300.1060 c) 300.1060 d) 300.1060 e) 300.1060 f) Section 300.1060 Vaccinations c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination, or the vaccination is medically contraindicated. (Section 2-213(b) of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act) e) A facility shall distribute educational information provided by the Department on all vaccines recommended		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 13 by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act) f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow policies and procedures for immunization of residents against pneumococcal disease in accordance with national standards of practice; failed to document the refusal and/or the benefits and side effects of the pneumococcal vaccine in the resident's electronic medical records; and failed to document in the resident's medical record that the resident was verbally screened for risk factors associated with hepatitis B and hepatitis C and whether or not the resident was immunized against hepatitis B. This deficient practice affected 4 residents (R6, R27, R63, and R134) reviewed for pneumococcal immunizations in a total sample size of 52 residents. Findings include: On 11/18/25 at 3:04pm, with V23 (Infection Preventionist), during review of records for R6, R27, R63, and R134 from admission date to 11/18/2025, there were no findings of documentation of pneumococcal vaccine offering or education of the vaccine as well as no documentation for R6, R27, R63, and R134 of being verbally screened for risk factors associated with hepatitis B and hepatitis C and whether or not the resident was immunized against hepatitis B. Review of physician orders for R1, Immunization records for R6, R27, R63, and R134 has no current information for the pneumococcal vaccination listed. On 11/18/25 at 3:04pm, V23 (Infection Preventionist) confirmed that R6, R27, R63, and R134 from admission			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 14 date to 11/18/2025 have no findings of documentation of pneumococcal vaccine offering or education of the vaccine and immunization records. R6, R27, R63, and R134 have no current information for the pneumococcal vaccination listed ss well as no documentation for R6, R27, R63, and R134 of being verbally screened for risk factors associated with hepatitis B and hepatitis C and whether or not the resident was immunized against hepatitis B. V23 said, "Education and consent or refusal of the pneumonia and flu vaccine should be obtained on admission by the nurse and documented in the record. I (V23) should be checking to make sure this is done. The purpose of this is to prevent the spread of infection and the virus. We (facility) currently do not screen for risk residents for risk factors for hepatitis B and C. We (facility) screen resident for TB (tuberculosis)." On 11/19/25 at 10:02am, V2 (Director of Nursing/DON) said, "Typically, if they hadn't had it (pneumococcal and influenza vaccine), we (nursing staff) call the family if they (residents) are not alert. It (obtaining and documenting influenza and pneumococcal vaccination status, consent, and refusal) should be done when admitted. The nurse should ask the resident on admission. The purpose for the vaccines is to ensure that we are offering it. Protect them (residents) from any infections." Facility policy titled "Influenza and Pneumococcal Immunizations," dated 4/21/22, documents, in part, "Purpose: To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal pneumonia. The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or resident's legal representative); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy. Pneumococcal Vaccine: Before offering the pneumococcal immunization, each resident or the resident's representative will be provided education regarding the benefits and potential side effects of the immunization. Each resident is offered a pneumococcal immunization per CDC recommendations (see CDC Pneumococcal Vaccine Timing for Adults reference table) unless the immunization is medically contraindicated, or the resident has already been immunized; A second pneumococcal vaccine will be offered only when necessary according to the CDC guidelines. The resident or the resident's representative has the opportunity to refuse immunization. The resident's medical record includes documentation that indicates, at a minimum, the		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 15 following: That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and That the resident either received or did not receive the pneumococcal immunization due to medical contraindications or refusal." Record review of facility policy titled, "Resident Rights," dated 1/04/2019, documents, in part, "To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. (C) (4 of 4) 300.1210 a) 300.1210 b) Section 300.1210 General Requirements for Nursing and Personal Care a) 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. Restorative measures shall include, at a minimum, the following procedures:			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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
S9999	Continued from page 16 Based on observation, interview and record review, the facility failed to apply splints/braces in accordance with the resident's comprehensive care plan; failed to administer enteral feeding in accordance with physician orders; failed to follow the resident's plan of care regarding enteral feeding. These failures affected 2 residents (R10, R15) reviewed for general nursing care. Findings include: R15's face sheet documents in part the following diagnoses: nontraumatic intracerebral hemorrhage, protein-calorie malnutrition, encounter for attention to gastrostomy, respiratory failure. R15's minimum data set (9/4/2025) documents in part that R15 is dependent on staff for administering enteral nutrition and R15 receives 51% or more of total calories through enteral feeding. R15's physician orders document in part an active enteral feeding order (8/30/2025), "two times a day Jevity 1.2 @ 80ml/hr x 20 hrs On at 2 pm Off 10 am or until total volume of 1600ml infused" On 11/18/2025 at 10:07 AM, R15 was observed resting in bed receiving enteral feeding via feeding pump. The container connected to the feeding pump was Jevity 1.5 kCal. This observation was confirmed with V43 (Licensed Practical Nurse). V43 checked the orders and affirmed that that was the incorrect enteral feeding and stated that the container should be 1.2 kCal. R15's care plan documents in part, that R15 requires tube (enteral) feedings, is at risk for weight loss, malnutrition/dehydration (5/24/24). Additionally, the care plan documents an active intervention, "Administer tube feeding and flushes as ordered." (5/2/2023) Facility policy titled, "Gastrostomy Tube- Feeding and Care" (Revised 8/3/2020) documents in part, "Purpose: To provide nutrients, fluids and medications per physician orders to residents requiring feeding through an artificial opening into the stomach..." R10's face sheet documents in part the following medical diagnoses including, but not limited to: anoxic brain damage, chronic respiratory failure, and functional quadriplegia. R10's minimum data set (8/22/2025) documents in part that R10 has range of motion impairment in both sides of R10's upper and lower extremity. Additionally, R10			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2025	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE COUNTRY CLUB HILL				STREET ADDRESS, CITY, STATE, ZIP CODE 18200 SOUTH CICERO AVENUE , COUNTRY CLUB HILLS, Illinois, 60478			
(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	
S9999	Continued from page 17 has a brief interview of mental status summary score of 12, indicating that R10 has mild cognitive impairment. R10's care plan (2/14/2025) documents in part, "(R10) Would benefit from use of Splint/Brace due to he/she is at risk for developing/has actual contracture related to: Extreme weakness and/or paralysis, Physical inactivity. Will tolerate use of splint without adverse reaction daily. Program to be performed at least 15 minutes daily per application schedule, 7 days/week through next review. Type(s) of splint: protector Location of application: Both hands Application schedule: On in am off in pm..." On 11/17/2025 at 10:46 AM, R10 was observed resting in bed with V47 (R10's Family Member) at the bedside. Observed contractures to R10's bilateral hands with no splints/braces in place. R10 stated that R10 used to have a brace but no staff put the brace on anymore. R10 affirmed that R10 would want the brace on and would want services to prevent range of motion decline. On 11/19/2025 at 10:31 AM, R10 was observed lying in bed with no splints/braces in place. V48 (Certified Nursing Assistant) affirmed that R10 was not wearing any splints or braces. V48 was unsure where the braces were. V48 searched R10's room and found 1 palm protector on a top of a dresser. V48 could not find any other palm protectors/braces/splints within R10's room. Facility policy titled "Application of Splints" documents in part that the purpose of splint application is for support, comfort or to aide in contracture prevention, and that a physician order/specific splint for the resident is needed. (B)		S9999				