

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 02/07/2026	
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				
	Investigation of Facility Reported Incident of 10-18-2025/2685948						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.120d)6)						
	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.						
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective						

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 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 accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to implement fall preventive measures for a resident who is a 2 person transfer assist due to increased weakness and behaviors. This deficiency affects one (R1) of three residents reviewed for Falls prevention program. This failure resulted in R1 being hospitalized and treated for a Closed Fracture of Left ankle. Findings include: R1 is a 57-year-old admitted to the facility on 2/13/2020 with the following diagnoses in part but not limited to: cerebral palsy, unspecified convulsions, spastic hemiplegic cerebral palsy, other disorders of muscle, reduced mobility, vascular dementia, essential hypertension, Paroxysmal atrial fibrillation, gastro-esophageal reflux disease, cardiomyopathy, hypothyroidism, autistic disorder, schizophrenia, bipolar disorder, generalized anxiety, unspecified fracture of shaft left fibula, depression, Facility Reported Incident dated 10/18/25 documents during transfer R1 was assisted by certified nurse aide, R1 was observed sitting on floor with her back to the bed with legs flat on the floor. R1 sustained Left Tibia Fibula Fracture. On 2/7/26 at 10:30AM, R1 said that she recalls when she fell and broke her ankle. R1 said that there was only one certified nurse aide present and was transferring her from bed to wheelchair and that the wheelchair was not positioned correctly and the certified nurse aide grabbed her from under the arms and stood her up and then let go of her from her left side and that's when she slid down to the floor. R1 said she has weakness to left arm. R1 said she was wearing her Ankle Foot Orthosis (AFO) brace and when she slid to floor, she heard a cracking sound and told the staff her leg hurt.	S9999					

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S9999	Continued from page 2 On 2/7/26 at 11:27AM, V3 (Registered Nurse) stated she was unsure of what transfer status R1 was prior to the fall, V3 said she was the nurse on duty when R1 fell on 10/18/25. V3 said there was only one staff member assisting her with the transfer on 10/18/25. R1 did sustain a fracture from fall. On 2/7/25 at 12:40PM, V5 (Licensed Practical Nurse) stated she was not aware of fall care plan intervention of two person transfer due to increased weakness and behaviors. On 2/7/26 at 1:40PM, V7 (Registered Nurse) stated that for all residents the care plan interventions are to be followed. On 2/7/26 at 2:20PM, V2 (Director of Nursing) stated that her expectations are for care plans to be updated as needed and staff to follow resident's interventions as indicated. On 2/7/26 at 2:35pm, V1 (Administrator) stated that care plans should be updated quarterly, annually and as needed and expect the staff to follow care plan interventions. The Post Fall Observation assessment dated 8/1/2025- indicating High Fall risk. GG self-care and mobility assessment dated 7/21/25 chair/bed to chair transfer- Dependent requiring two staff assist. GG- Functional Abilities and Goals assessment dated 7/24/25- chair/bed to chair transfer- Dependent- requiring two staff assist. MDS section GG- Functional abilities dated 7/23/25- Putting on/taking off footwear- Dependent requiring two staff assist. MDS section GG- Mobility dated 7/23/25- chair/bed to chair transfer- Dependent requiring two staff assist. Care plan dated 2/22/23 R1 would benefit from use of left Ankle Foot Orthosis (AFO) Brace, related to diagnoses of cerebral palsy, spastic hemiplegic cerebral palsy, vascular dementia. Intervention: Observe for signs/symptoms of pain, discomfort or intolerance. Care plan dated 1/8/24 R1 is at risk for falls r/t gait/balance problems, poor			S9999			

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S9999	Continued from page 3 communication/comprehension, history of falling, spastic hemiplegic cerebral palsy exhibits poor judgment exhibited by intentions placing self on floor. Interventions: Moderate to substantial assist x two staff with gait belt for all transfers due to increased weakness and behavior. Care plan dated 1/24/25 R1 has ADL Self Care Performance Deficit related to dementia and disease process of cerebral palsy. Presents with diagnosis of cerebral palsy. Noted with limitations to left foot requiring left ankle foot orthosis brace/boot. Requires mechanical Hoyer lift x two person assist with transfers. Non-ambulatory requires wheelchair for mobility. Care plan dated 4/30/24 R1 requires use of full body lift for transfers. Intervention: Full body lift with two person assist for all transfers. Facility Policy on Fall Prevention Program- revised 11/21/17 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. Guidelines: The Fall Prevention Program includes the following components: -methods to identify risk factors -methods to identify residents at risk -assessment time frames -use and implementation of professional standards of practice -immediate change in interventions that were successful Periodic quality assurance audit activities of records relating to falls that exhibit adherence to facility policies and implementation of the plan of care. Standards:			S9999			

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S9999	Continued from page 4 -A fall risk assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. -A fall risk assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. -Safety interventions will be implemented for each resident identified at risk. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program. Each resident will be screened by a specialist therapist at the time of admission, quarterly, after each fall, as appropriate and with significant change in the residents' mental and functional abilities. Transfer conveyances shall be used to transfer residents in accordance with the plan of care. Facility Policy on Transfer-Manual Gait Belt and Mechanical Lifts- revised 1/19/18 Purpose: In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents. Guidelines: 5. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following: 2=2 person transfer with gait belt (ONLY when use of mechanical lift is not possible) 6. Resident transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed. (A)			S9999			