

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Elevate Care Country Club Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 18200 South Cicero Avenue Country Club Hills, IL 60478	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570</p> <p>Based on interview and record review, the facility failed to follow their grievance policy by not acknowledging a concern written by a resident representative. This failure affected one of one (R1) resident reviewed for grievances.</p> <p>Findings include:</p> <p>R1 was originally admitted to the facility [DATE] wit diagnoses that included but are not limited to malignant colon cancer. According to R1's electronic health record, progress notes of [DATE] indicate R1 went to an outpatient oncology appointment and was hospitalized with a diagnosis of adult failure to thrive. While in the hospital, and due to R1's sudden decline in health, R1's healthcare proxy elected for R1 to admit to hospice services upon returning to the facility. R1's consent for hospice services was signed in the hospital on [DATE].</p> <p>R1 returned to the facility on [DATE] and was admitted and assessed by hospice care services on [DATE]. Hospice orders were written at the time of assessment, however, were not transcribed to R1's electronic health record. As a result, R1 did not receive any of the comfort medications ordered, from [DATE] to [DATE].</p> <p>On [DATE] at 9:10am V9 (R1's Representative) stated they went to visit R1 on [DATE]. V9 stated walking in R1's room, V9 noticed that R1's face was contorted in pain and R1 was gripping the sheets. V9 went on to explain that there was confusion among the nursing staff because there was medication available to give R1, however no orders were transcribed in the chart.</p> <p>During this interview, V9 began crying and stated my biggest heartache is that [R1] sat there in pain before he died in the facility. [R1] had been [in the facility] since Sunday and Thursday was the first time he got morphine and then on Friday, [R1] died . V9 stated these concerns were expressed to V1 Administrator via email a few weeks ago, however no facility staff have reached out to address the concerns as written.</p> <p>On [DATE] at 3:30pm V1 administrator stated regarding Grievances, any resident, family member or outside person is able to relay a concern to the facility staff. V1 stated no matter if the concern came via phone call, face to face or email the concern finds its way on a grievance form. V1 was unaware of any concerns related to R1 and had not received any documented concerns since R1's passing.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V9 provided the surveyor a forwarded email sent to V1 Administrator on [DATE]. The email address was confirmed as provided during this survey.</p> <p>Facility grievance forms were reviewed from [DATE] to current and no grievance was filed for V9.</p> <p>Facility Policy Grievances revised [DATE] states in part; Purpose: To ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus. Guidelines: Grievances may be filed orally (meaning spoken), in writing, or anonymously. Grievances may also be filed anonymously through the Corporate Compliance Hotline. Contact information for the Corporate Compliance Hotline shall be posted in prominent locations through the facility. All written grievances shall include: The date the grievance was received; A summary statement of the grievance, Department assigned to investigate; Steps taken to investigate the grievance; Summary of the pertinent findings or conclusions regarding the concerns(s); Statemen as to whether the grievance was confirmed or not confirmed; Corrective action taken or to be taken by the facility as a result of the grievance, including measure taken to prevent further potential violations of any resident right while the alleged violation is being investigated. ; The date the written decision was issued to the resident or the complainant. Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days (excludes weekends and holidays). Under certain circumstances, additional time may be needed to complete an investigation and implement measures to resolve the grievance. In such cases, the resident or complainant should be notified of the extension.</p> <p>Copies and results of grievances filed shall be maintained for a period of no less than 3 years from the issuance of the grievance decision.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570</p> <p>Based on interview and record review, the facility failed to transcribe physician orders for comfort care medications for a resident admitted to hospice care services. This failure affected one (R1) of five residents reviewed for physician orders and resulted in R1 having untreated pain for several days before expiring in the facility.</p> <p>Findings include:</p> <p>R1 was originally admitted to the facility [DATE] with diagnoses that included but are not limited to malignant colon cancer. According to R1's electronic health record, progress notes of [DATE] indicate R1 went to an outpatient oncology appointment and was hospitalized with a diagnosis of adult failure to thrive. While in the hospital, and due to R1's sudden decline in health, R1's healthcare proxy elected for R1 to admit to hospice services upon returning to the facility. Consent for hospice services was signed in the hospital on [DATE].</p> <p>R1 returned to the facility [DATE]. According to nurse progress notes, V3 LPN (Licensed Practical Nurse) received R1 upon arrival, and transcribed orders received from the hospital. An order for hospice services was written on the Physician's Order Sheet [DATE].</p> <p>On [DATE] at 9:10am V9 (R1's Representative) said they went to visit R1 on [DATE]. V9 stated walking in R1's room, V9 noticed that R1's face was contorted in pain, and R1 was gripping the sheets. V9 stated, since the hospitalization, R1 was confused and would often say no to anything R1 was being asked. When V9 saw R1's presentation, V9 immediately went to find a nurse, however the nurses were not immediately available at the nursing station. V9 saw an unidentified staff member enter the room and relayed the concern of R1 showing overt signs of pain. V9 and the staff member found the nurse on duty (V10 LPN), V9 stated V10 relayed that R1 had morphine on hand and showed it to V9. However, V10 stated there was no order written and therefore could not administer it to R1. V9 stated, the nursing manager (V2 Director of Nursing) got involved and got an order for R1 to receive the medication and the nurse gave it.</p> <p>During this interview, V9 began crying and stated my biggest heartache is that [R1] sat there in pain before he died in the facility. [R1] had been [in the facility] since Sunday, and Thursday was the first time he got morphine and then on Friday ([DATE]), [R1] died .</p> <p>According to hospice notes, R1 was assessed by a hospice nurse and admitted to hospice services the following day of readmission on [DATE]. Written hospice orders included comfort kit medications orders which included morphine sulfate for pain, lorazepam for anxiety and restlessness and acetaminophen suppositories for fever and pain. Hospice RN (Registered Nurse) and facility nurse V7 LPN signed that orders were reviewed and received.</p> <p>At the time of this survey, review of Physician's Order Sheet for [DATE] did not include any transcription of the hospice orders for medications.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>V6 is representative from the hospice company caring for R1. On [DATE] at 3:40pm V6 stated R1 was transferred to the facility over the weekend, and the (hospice) nurse came to assess and admit R1 to hospice the following day [DATE]. While the nurse was at the facility, medication and other orders were confirmed with the facility nurse on duty for R1. V6 stated the nurse was identified as V7 as evidenced by name and signature on the admission forms. V6 stated the hospice company provides the comfort kit medications from a collaborating pharmacy and the medications usually arrive before or at the time the admitting nurse comes so that the medications are available to be reviewed during admission. V6 also provided a pharmacy sheet manifest that listed V8 LPN as receiving medications from the hospice pharmacy. The medications delivered included five milliliters of Morphine Sulfate 20mg/ml (milligrams/milliliter) solution received by V8 on [DATE] at 1:49pm. Hospice Comprehensive Assessment notes that the admitting hospice nurse's time in was for 1:50pm, and time out 3:00pm.</p> <p>Hospice Chaplain noted visiting R1 on [DATE]. Hospice Support Services Log written by the chaplain included a care plan open for pain. During the Chaplain visit R1 was noted to exhibit signs of pain: [R1] reports no, grimacing with anticipation.</p> <p>R1's Nursing Progress Note dated [DATE] at 5:32am stated [R1] observed with shortness of breath while lying flat, resident repositioned, head of bed elevated Vital signs taken, [oxygen] given via [nasal cannula]. [R1] appears comfortable at this time, will continue to monitor. Resident recently enrolled in hospice services. will continue to monitor.</p> <p>On [DATE] at 11:53am V2 DON (Director of Nursing) stated, they were not aware of any concern related to R1's pain medication not being available, however remembered helping the nurse on duty with orders on [DATE]. V2 stated the nurse (V10 LPN) was fairly new and we had to call hospice directly for the orders because R1 didn't have any orders for the morphine documented in the electronic health record. V2 stated they didn't know if the medication was available, and I didn't ask but I did put the orders in the [electronic health record]. V2 went on to say, at the time of the hospice nurse's assessment of the residents admitting to hospice care, facility nurses are expected to review any new orders provided by hospice relay them to the primary provider and transcribe the orders onto the Physician Order Sheet. Nurses are then expected to write a progress note indicating this action.</p> <p>Working nursing schedules were reviewed and confirmed V7 LPN and V8 LPN as the nurses working R1's unit the 7am-3pm shift on [DATE]. On [DATE] at 3:33pm V7 LPN stated the unit was short one nurse that day and it was likely very busy. V7 recalled taking care of R1 on [DATE] but did not recall receiving hospice orders.</p> <p>On [DATE] at 12:07pm V8 LPN stated they could not recall working the unit that morning and did not recall receiving medications for R1.</p> <p>The Physician Order Sheet indicated three orders documented by V2 on [DATE] at 11:03 for Morphine Sulfate: Morphine Sulfate (Concentrate) Solution 20 mg/ml (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 10mg(0.5ml); Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 5 mg by mouth every 1 hours as needed for dyspnea/ air hunger/ shortness of breath/ respiratory rate give 5mg.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Policy for Transcription of Physician Orders no revision date states in part: Purpose: 1. To establish the procedure by transcribing new physician orders. 2. To document and give clear indication that physician orders have been processed and action taken. Admission Protocol or Return From Hospital Stay: 1. Transcription of physician order: a. Carefully, review transfer record and discharge summary from the hospital or the transfer record from another health care facility. B. The licensed nurse should notify the physician of the resident's admission, clinical condition and findings, review and clarify transfer orders and previous orders, as applicable. C. After each order is entered in the Physician Order tab of the chart, check that all orders were entered correctly. D. After physician verification, the licensed nurse completes a progress note that denotes the physician is aware of the admission and that the orders were verified. 6. Medication and treatment orders are to be transcribed in the physician order tab of the electronic medical record. Directions must be understandable (without abbreviations other than the approved abbreviations) by all staff members who are responsible for medication and treatment administrations.</p> <p>Hospice Services Agreement contract with the facility signed [DATE] states in part [hospice provider] shall also provide all prescription drugs, pharmaceuticals, medical equipment and supplies relating to a resident Hospice Patient's terminal illness as may be specified in such Resident Hospice Patient' Plan of Care. Services to be provided by Nursing Facility: A. Room and Board. 1. Nursing Facility shall provide Room and Board services in the form of personal care services to each Resident Hospice Patient. It is nursing Facility's responsibility to continue to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary giver at home at the same level of care provided before hospice care was elected. Such Room and Board services shall include but not be limited to such services as: 3- Administration of medication as prescribed in the Plan of Care.</p>		