STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145011	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Evanston L & R, The	500 Asbury Street Evanston, IL 60202

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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews and records review, the facility failed to follow their policy to ensure a resident was free from abuse by one staff member being physically abusive toward one resident (R1), out of seven residents reviewed. This failure resulted in R1 experiencing emotional trauma. Findings include: R1's current face sheet documents R1 is an [AGE] year-old individual initially admitted to the facility on [DATE], with medical diagnosis that include but not limited to: displaced fracture of greater trochanter of left femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R1's MDS (Minimum Data Set) section C documents R1's Brief Interview for Mental Status (BIMS) dated August 19, 2024, as 9/15, indicating R1 has moderate cognitive impairment. R1's MDS section GG-Functional Abilities documents R1 requires Partial/moderate assistance eating, Upper body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, Chair/bed-to-chair transfer. R1 requires partial to moderate assistance with Toilet transfer, and section GG further documents R1 needs Substantial/maximal assistance with Oral hygiene, Toileting hygiene, Shower/bathe self, Lower body dressing. On 09/08/2024 at 9:30 AM, V4 (Licensed Practical Nurse-LPN) who speaks Spanish and works with R1, interpreted for surveyor what R1 was saying in Spanish. R1 was observed in her room lying in bed awake, with R1's wheelchair next to R1's bed. R1 was alert and oriented to person, place, and situation and stated a female staff member with dark skin and regular height V3 (Certified Nursing Assistant), forcefully pushed R1 on R1's wheelchair and was hitting R1 when R1 tried to get up from her wheelchair. R1 stated this happened in the hallway next to R1's bathroom. R1 stated V3 held R1 by R1's shoulders and was pushing R1 down forcefully into the wheelchair and hitting R1. R1 stated she asked God why V3 was hitting R1 and R1 had not done anything wrong to V3. R1 was observed to be sad when talking about what happened to her and stated if R1 had strength, she would hit V3 back and pulled V3's hair, but because R1 does not have strength to hit V3, R1 prayed to God to help and protect R1. R1 started crying and stated her parents never hit her, and R1 did not know why V3 was rough towards R1 and hitting R1 on the shoulders. R1 stated she was screaming for help, but no one came to R1's rescue. R1 stated she is always afraid now, so R1 tries to look for good people in the facility to protect R1, and R1 will never forget V3 hit her. R1 further stated she was afraid of retaliation for speaking about what happened to her and R1 stated she did not want to talk about it anymore because it made R1 sad. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Grove of Evanston L & R, The		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Asbury Street Evanston, IL 60202	

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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 09/08/2024 at 11:52 am, V6 (Activity Aide) stated she was in the dining room on the second floor opening her computer and was sitting down under the TV and V6 could see R1's bathroom from where V6 was sitting. V6 stated V6 observed R1 seated on the toilet then R1 got up and V3 was outside R1's bath. V6 stated she observed V3 push R1 back on to the toilet roughly and R1 fell on the toilet sideways. V6 stated R1 was screaming and crying and speaking Spanish stating Why are you doing this to me. I did not do anything to you. V6 stated when R1 screamed, nobody went to see what was going on. V6 stated she understood what R1 was saying because V6 speaks Spanish. V6 stated V3 was not startled by R1 and as soon R1 got up from the toilet, V3 pushed R1 back to the toilet. V6 stated the bathroom door was open when R1 was using the bathroom and V3 was right there with R1 looking at R1 as R1 was using the bathroom. V6 stated R1 was screaming and crying after being pushed by V3, then V3 assisted R1 to the wheelchair, got her dressed and brought R1 to the dining room. V6 stated V6 spoke to R1 and R1 was crying and told V6 that R1 does not know why V3 treats R1 like that because R1 did not do anything bad to V3. V6 stated pushing a resident roughly is a form of abuse. V6 stated before V6 left the facility for the day at about 5:30pm she reported to V8 (Licensed Practical Nurse-LPN) what V6 had witnessed because V8 was the nurse on duty for R1. On 09/08/2024 at 4:36pm V2 (Director of Nursing) and surveyor toured R1's floor and observed that sitting in the dining room near the TV, R1's bathroom is visible. V2 stated if a person is sitting in the dining room near the TV, the person can observe R1's bathroom directly. On 09/08/2024 at 11:10am, V3 (Certified Nursing Assistant -CNA) stated via phone that on Saturday 08/10/2024, V3 stated around 2:10pm, V3 was taking her break in the dining room and V8 come to the dining room and told V3 to watch R1 because R1 is a high fall risk, and R1 was trying to get out of the wheelchair. V3 stated she rushed to R1 and told R1 to sit down because R1 was almost falling. V3 stated she did not push R1 and just put her hand on R1's shoulders to seat her down. V3 stated R1 got agitated and started crying and stated V3 put her hands on R1's shoulders and asked R1 to sit down forcefully. On 09/08/2024 at 12:42pm, V8 (Licensed Practical Nurse-LPN) stated via phone that on 08/10/2024, V8 did not observe anything between R1 and V3 and it was V6 (Activities Aide) who reported to V8 that R1 wanted to use the washroom and V6 witnessed V3 being aggressive while V3 was transferring R1 from the wheelchair to the toilet. V8 stated V6 did not tell V8 right away about the incident, and V6 when to the front desk and called V8 after the shift was over and V3 had already gone home. V8 stated V6 told her this happened right before the first shift was over, therefore V8 was not able to ask V3 what happened. V8 stated they called V2 to inform V2 what was reported by V6 to V8, and then V1 called V8 to ask V8 what had happened. V8 stated she told V1 (Administrator) that V8 did not witness anything and that it was V6 who told V8 that V6 had witnessed V3 being aggressive with R1 during bathroom care. V8 stated she has heard V3 speak loud to R1 because of language barrier because R1 is Spanish speaking and is not fluent in English and V3 speaks broken English. On 09/08/2023 at 1:55pm, V9 (Social Services Director) stated she knows there was an incident report done regarding allegation of V3 and abuse on 08/10/2024, with R1. V9 stated that V3 was being unkind and rude to R1 while assisting R1 to the toilet. V9 stated after the abuse allegation, she V9 did not complete any assessments for R1. V9 stated she spoke to R1 based on report and offered R1 general emotional support, but V9 did not ask R1 what happened because V9 did not want to open the wounds of what happened with R1. V9 stated V9 did not discuss, investigate, or offer R1 support related to the incident. V9 stated she did not document any interactions between V9 and R1 regarding the abuse allegation because V9 interactions with R1 are ongoing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Evanston L & R, The	500 Asbury Street Evanston, IL 60202

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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 09/09/2024, V9 stated via email that R1's most recent BIMS (Brief Interview for Mental Status) scored a 09/15, which suggests R1 has moderately impaired cognition. On 09/08/2024 at 2:37pm, V2 (Director of Nursing -DON) stated on 08/10/2024, V8 (LPN) was the nurse on duty on R1's side of the unit and V8 called V2 stating that V6 (Activities Aide) had told V8 that V3 (CNA) had pushed R1 on the wheelchair in the dining room after R1 stood up. V2 stated V8 stated R1 was ok, V8 had notified V1(Administrator/Abuse Coordinator), and R1's physician and R1's family. V2 stated she spoke with R1 on 08/12/2024 when V2 come back to work and R1 was crying stating staff, staff. V2 stated interpreter services by phone was not working well on that day, so V2 did not understand R1 well. V2 stated there are nursing staff who can speak Spanish and can interpret for V2 what R1 was saying, but V2 did not use any of the staff to complete investigations. V2 stated she did not document anything regarding R1's abuse allegation investigations because she (V2) did not do a complete follow up with R1 about what happened. V2 stated V3 was suspended the same day on 08/10/2024, and V3 resigned on 8/16/2024. V2 stated R1's care plan was not updated after the incident/abuse allegation of 08/10/2024. V2 stated If it's not documented, it is not done. V2 stated no one; nurses, Social Services documented the abuse allegation by R1 on 8/10/2024 or any assessments completed after the allegation. V2 stated R1 should not be left alone in the bathroom because R1 is a high fall risk, and CNAs are supposed to bring all supplies to the bathroom when they take R1 to the bathroom. On 09/08/2024 at 3:31pm, V1(Administrator) stated he received a call on 8/10/2024 from V8 (LPN) around 5:00pm stating that on 08/10/2024, V8 told V1 that V6 heard R1 and V3 being loud in the bathroom and when R1 stood up, V3 told R1 to sit down in a loud voice because V3 was scared R1 was going to fall, and R1 shouted no. V1 stated V1 then called V6 to follow up and V6 repeated the same story V8 had told V1, and that V3 put V3's hands on R1's shoulders to steady R1. V1 stated R1 told V1 that R1 does not like V3 because V3 was hard and mean to R1. V1 stated R3 was suspended immediately and then R1 resigned because she did not like being suspended. On 09/08/2024 at 4:00pm, V10 (Social Services Designee), V10 stated she interviewed R1 on 08/12/2024 using the interpreter services regarding the allegation of abuse by V3 on 08/10/2024. V10 stated R1 was upset when telling V10 what V3 did to R1. V10 stated R1 said V3 yelled at R1 because R1 was standing off the toilet, and V3 put her hands on R1's shoulders firmly. V10 stated yelling to residents is not allowed and it's against their rights and staff cannot yell at residents especially when the resident is trying to go to the bathroom. V10 stated she did not document the conversation with R1 and stated she was supposed to document to show that the conversation/assessments she (V10) had with R1 happened. V10 stated she has seen R1 in the dining room or in hallways but V10 has not gone back to ask R1 how R1 feels about the alleged abuse. R1's care plan dated 07/08/2024 documents R1 is incontinent of bladder and bowel. Abuse policy titled 07/12/2024 documents: -It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely thorough investigations of abuse. -Abuse is willful infliction of mistreatment, injury, unreasonable confinement, intimidation, or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse. -Types of abuse and examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and rough handling.