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	07/18/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy in alerting a resident's responsible party of a change in condition for weight loss and new identified wound. This affected one resident (R1) of three residents reviewed for notification of change in condition. Findings include:On 7/16/25 at 12:00PM, V1 (Administrator), said that about one hour before R1 was discharged V5 (Wound Care Nurse) was notified about the new wound identified on R1. When V5 went to see R1 the resident was discharged , did not notify the Physician because the resident had already left the facility.On 7/16/25 at 12:15PM, V2 (Director of Nursing), said if a new wound was observed on the resident, then nurse will notify MD (Medical Doctor) to obtain treatment orders and notify family. V2 said she was made aware of the new wound identified on R1 by V3 (Registered Nurse). V2 said that for weight loss identification the facility will notify Nurse Practitioner, and registered dietitian will be notified. V2 said that family was not notified of changes in weight and the responsible party was not made aware of wound identified prior to discharge. On 7/16/25 at 2:05PM, V3(Registered Nurse) said that he was the nurse who discharged R1 on 7/14/25, R1 had a new wound, said it was about 2cm (centimeters) by 2cm, no discharge and covered the wound with a dressing. V3 said he did not notify the Physician or Nurse Practitioner.R1 is admitted on [DATE] with diagnosis listed in part but not limited to Parkinsonism, difficulty in walking, unspecified lack of coordination, anemia, other specified anxiety disorder, insomnia, vertigo of central origin, spinal stenosis, retention of urine, multiple fractures of ribs. admission Braden Assessment on 6/24/25- Braden/skin assessment indicated R1 is at high risk for developing pressure ulcers/skin impairments. Physician order summary report indicates may use pressure relieving device when indicated, skin-apply house stock topical moisturizer, pressure reducing chair cushion to wheelchair, turning and repositioning at regular intervals, Weights upon admission/readmission x4 weeks, then monthly. Care plan for Impaired mobility function related to weakness, unsteady gait, impaired physical function, neuropathic pain poor safety awareness-. At risk for alteration in nutritional status related to alcohol use disorder- monitor for signs and symptoms of dehydration and weight loss. High Risk for pressure sore development, based on Braden score of 17 and related to diagnosis- apply pressure relieving cushion to the wheelchair, Registered dietician recommendations as needed, skin check every shift. Pay special attention to bony prominences. Assess skin during bed bath/shower and routine care. Facility Policy on Notification for Change of Condition- revised 7/2/25.Policy StatementThe facility will promote care to residents and provide notification of resident change in condition status. Procedures1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the residents legal representative or an interested family member when there is:b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).Facility Policy on Weights-revised 7/3/25.Policy Statement It is the facility's policy to obtain resident's monthly weight unless otherwise ordered differently by the physician. For a resident who is on dialysis, the resident's dry weight will also be obtained monthly. Procedures 1. During the 1st week of the month, the restorative staff or designee will weigh each resident to fulfill the monthly weight requirement. For the dialysis residents, their dry weights will be obtained on the first week of the month immediately after the residents come back from their dialysis. 2. The monthly weights will be reflected on the resident's individual chart. 3. The significant weight changes (monthly (5%), quarterly (7.5%), and every 6 months (10%) will be assessed and addressed by the IDT which includes but not limited to the Dietician, Physician, Medical Specialist, Speech Therapist, Nutritionist, and Nurses.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess newly identified wound. The facility also failed to notify physician and obtain wound care treatment. This deficiency affects one (R1) of two residents reviewed for Wound/Pressure Ulcer Prevention and management. Findings include:On 7/16/25 at 11:50 AM, V4 (Social Service Director) said if a new wound is identified then we notify our wound care nurse, then she will evaluate and decide if the resident will be able to go home and home health is notified as well.On 7/16/25 at 12:00PM, V1 (Administrator), said that about one hour before R1 was discharged V5 (Wound Care Nurse) was notified about the new wound identified on R1. When V5 went to see R1 the resident was discharged , didn't not notify the Physician because the resident had already left the facility.On 7/16/25 at 12:15PM, V2 (Director of Nursing), said if a new wound was observed on the resident, then nurse will notify MD (Medical Doctor) to obtain treatment orders and notify family. V2 said she was made aware of the new wound identified on R1 by V3 (Registered Nurse).On 7/16/25 at 12:30PM, V6 (Nurse Practitioner) said she was not aware of any new wounds found on R1 early in the morning before discharge, R1 did not complain of any pain or any signs of distress. V6 said she is unaware of the possibilities of R1 developing sepsis and dehydration after discharge.On 7/16/25 at 12:45 PM, V5 (Wound Care Nurse) said she was notified that R1 had a wound to lower back an hour before discharge and did not assess the resident, no measurements were taken. The MD and family were not notified. V5 said that R1 had already been discharged . On 7/16/25 at 2:05PM, V3 (Registered Nurse) said that he was the nurse who discharged R1 on 7/14/25. R1 had a new wound, and it was about 2cm (centimeters) by 2cm with no discharge. He covered the wound with a dressing. V3 said he did not notify the Physician or Nurse Practitioner and did not notify the family. On 7/17/25 at 11:00AM, V7 (Certified Nurse Aide) said she was taking care of R1 getting him changed before he was going home. V7 observed a blister to the lower back. V7 said it was small and black in color not open and informed V3.R1 is admitted on [DATE] with diagnosis listed in part but not limited to Parkinsonism, difficulty in walking, unspecified lack of coordination, anemia, other specified anxiety disorder, insomnia, vertigo of central origin, spinal stenosis, retention of urine, multiple fractures of ribs. admission Braden Assessment on 6/24/25- Braden/skin assessment indicated R1 is at high risk for developing pressure ulcers/skin impairments. Physician order summary report indicates may use pressure relieving device when indicated, skin-apply house stock topical moisturizer, pressure reducing chair cushion to wheelchair, turning and repositioning at regular intervals, Weights upon admission/readmission x4 weeks, then monthly. Care plan for Impaired mobility function related to weakness, unsteady gait, impaired physical function, neuropathic pain poor safety awareness-. At risk for alteration in nutritional status related to alcohol use disorder- monitor for signs and symptoms of dehydration and weight loss. High Risk for pressure sore development, based on Braden score of 17 and related to diagnosis- apply pressure relieving cushion to the wheelchair, Registered dietician recommendations as needed, skin check every shift. Pay special attention to bony prominences. Assess skin during bed bath/shower and routine care. Facility Policy on Wound Care Guidelines- revised 1/24/24OVERVIEW OF THE PROGRAM: This facility adheres to the Federal and State regulatory requirements for wound care management and the care guidelines for wound care established by the National Pressure Injury Advisory Panel. The goal of this care guidelines is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in the facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure injuries, and the purpose of the treatment focused recommendations is to provide evidence-based guidance on the most effective strategies to promote pressure injury/ulcer healing. PROCEDURES: 1. Timely identification of residents assessed to be at risk for skin breakdown. a. The Braden Scale must be completed by a licensed nurse on admission/re-admission and weekly for the first 4 weeks of admission/re-admission in the facility. A re-assessment shall be completed monthly, and as often as needed if there's a significant change in status of MDS. b. The scores from the Braden Scale and Clinical Evaluation should be interpreted/ calculated to determine level of risk: Low Risk High Risk c. Each risk factor and potential cause(s) identified should be reviewed individually and addressed into the resident's care plan. d. Facility shall develop a plan of care and implement intervention according to the resident's Braden Scale and Clinical Evaluation or identified individual risk factors. 10. Pressure Injuries Treatment a. Initiate wound care treatment upon identification of