

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 02/05/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observation, interview, and record review the facility failed to ensure resident care areas were maintained in a clean, safe, and homelike condition by failing to ensure resident's rooms were clean, failing to adequately clean resident's care equipment after use and stored in a clean condition, and failing to keep resident's room furniture free of damage. These failures apply to six of six residents (R5, R10, R60, R62, R81, and R88) reviewed for environment.</p> <p>Findings include:</p> <p>R5 is an [AGE] year-old female with a diagnoses history of Dementia, Parkinson's Disease, Schizophrenia, Age Related Osteoporosis, and History of Falling who was admitted to the facility 06/29/2020.</p> <p>R10 is an [AGE] year-old female with a diagnoses history of Dementia, Parkinson's Disease, and Epilepsy who was admitted to the facility 10/08/2023.</p> <p>R60 is a [AGE] year-old female with a diagnoses history of Dementia, Inner Ear Disorder of Both Ears, and a History of Falling who was admitted to the facility 09/01/2021.</p> <p>R62 is an [AGE] year-old male with a diagnoses history of Dementia, Spinal Fusion, Paralysis of a Single Limb, Heart Failure, and History of Falling who was admitted to the facility 03/26/2020.</p> <p>R81 is a [AGE] year-old male with a diagnoses history of Impaired Brain Function, Severe Muscle Tissue Breakdown, History of Falling, and Need for Assistance with Personal Care who was admitted to the facility 01/16/2023.</p> <p>R88 is an [AGE] year-old male with a diagnoses history of Parkinson's Disease, Heart Failure, and Need for Assistance with Personal Care who was admitted to the facility 12/13/2024.</p> <p>On 02/03/25 at 10:35 AM, there was a PPE (Personal Protective Equipment) bin outside a resident's room on the first-floor hallway soiled with dust, and medical equipment in the hall near the bin soiled with multiple droppings.</p> <p>On 02/03/25 at 10:50 AM, V2 (Director of Nursing/DON) stated the medical equipment sitting in the hall near the PPE bin is a bladder scan machine that is not being used and it should be covered. V2 covered the soiled bladder scan machine with plastic without cleaning it.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/03/25 at 10:52 AM, R81's room wall had a cord hanging out of it and nothing hooked up to the cord and his clothes cabinet had a missing drawer, multiple broken drawer handles, and had dust buildup. R81 stated he has reported the condition of his clothes cabinet and staff also see it but nothing has been done.</p> <p>On 02/03/25 at 11:02 AM, R88 was lying in his bed with his oxygen cannula on and his oxygen machine was seen with a heavy amount of dust.</p> <p>On 02/03/25 at 11:05 AM, multiple PPE bins were outside of residents rooms on the 1st floor hallway with a heavy buildup of dust and some residue stains.</p> <p>On 02/03/25 at 11:44 AM, R5's bed railings on both sides were heavily soiled with a brownish red substance, a pillow had a heavily stained personalized pillow case sitting beneath her feet near the foot of her bed, her bedside drawers and vents had a heavy presence of dust and particles, her blinds had a heavy amount of dust, her head board had spots/stains, her bedside table was soiled with substances and dusty, a toothbrush was sitting on top of it with a dark buildup in the bristles, a remote control was sitting on top of it with a residue in between the dials, and her room garbage can was without a bag and had heavy buildup in the bottom.</p> <p>On 02/03/25 at 11:52 AM, R10's tube feeding equipment was attached to her and operating, heavily soiled with substances. Her oxygen cannula on her face and her oxygen machine was seen with a heavy buildup of dust and particles, blind's near her bed had a heavy buildup of dust, the nightstand drawers were left open with several care items sticking out of it, her bed rails were soiled with residue, the footboard pressure relieving machine was seen with a buildup, and her head board and walls behind her had spots and stains. R60's night stand had a heavy amount of dust and residue, and her bed frame underneath the head of her bed had a heavy buildup and trash. R10 and R60's room floor was seen with trash and their shared bathroom with soiled surfaces.</p> <p>On 02/03/25 at 11:59 AM, R62 was in his room lying in his bed, R62's bathroom garbage bin was soiled with a substance running down the side, his room floors were dirty and had trash on them. His bathroom sink had a significantly heavy calcified buildup around the faucet.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/04/2025 from 11:50 AM - 12:11 PM, V2 (DON) stated all resident's PPE bins should be kept clean and also their care equipment even when not in use. V2 stated if housekeeping staff are cleaning daily there shouldn't be any visible stains or dust left behind on care equipment or in their rooms. V2 made observations with surveyor of R5's room; surveyor observed R5's room to be in the same unclean condition as observed by surveyor on 02/03/2025 at 11:44 AM and V2 also confirmed these observations. When asked by surveyor if R5's room should be in the observed unclean condition V2 stated housekeeping comes in and cleans daily and confirmed that R5's room and furnishings are not clean and should be. V2 stated R5's pillowcase should have been cleaned in the laundry. V2 made observations with surveyor of R10 and R60's room; surveyor observed R10 and R60's room to be in the same unclean condition as observed by surveyor on 02/03/2025 at 11:52 AM and V2 also confirmed these observations. When asked by surveyor if R10 and R60's room should be in the observed unclean condition V2 stated oxygen equipment should not be found with dust and substances, care items should be placed inside the drawer when not in use, and all of R10 and R60's room furnishings and equipment should be maintained in a clean condition. V2 confirmed that residents rely on staff to keep their rooms in clean condition. V2 made observations with surveyor of R81's room and surveyor observed R81's room to be in the same condition as observed by surveyor on 02/03/2025 at 10:52 AM. V2 also confirmed these observations. V2 confirmed and agreed that staff enter the resident's rooms daily and if they observed R81's furniture damaged they should have addressed it and should have had the cord removed from his wall. V2 stated housekeeping and maintenance are responsible for room cleaning and maintenance.</p> <p>On 02/05/25 at 11:55 AM V2 (DON) stated R62 does use his bathroom and is dependent on staff for showers. V2 stated housekeeping staff are responsible for keeping R62's room clean including cleaning the floors and removing trash. V2 stated R62's bathroom faucet should be cleaned by housekeeping and there shouldn't be any heavy build up around the faucet.</p> <p>The facility's General Housekeeping Policy received 02/04/2025 states:</p> <p>The facility will ensure that the facility and resident rooms will be clean, and sanitary through housekeeping services.</p> <p>The housekeeping staff will clean and sanitize the resident rooms and bathrooms daily.</p> <p>The facility's Medical Care Equipment, Instruments and Health IT Devices Infection Control Plan Policy received 02/04/2025 states:</p> <p>It is the policy of this facility to prevent infection and create/maintain a safe environment for the residents, through proper cleaning and sanitizing of medical care equipment, instruments and or other related health devices.</p> <p>After equipment is properly cleaned, it may be stored in a clean bag and labeled Ready For Use and shall be moved to a clean storage location.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344</p> <p>Based on interview and record review, the facility failed to provide effective fall interventions and adequate supervision for a resident while smoking. This failure applied to one (R21) of one resident reviewed for falls.</p> <p>Findings include:</p> <p>R21 is a [AGE] year old male who was originally admitted to the facility on [DATE] and continues to reside in the facility. R21 has multiple diagnoses including but not limited to the following: dysarthria, lack of coordination, abnormalities of gait and mobility, history of falling, and vertebra fracture.</p> <p>On 2/4/26 at 1:20PM, observed a smoking break and spoke with V19 (Activity Aide). It is to be noted that there were 7 residents present (5 in wheelchairs and 2 with walkers) smoking with 2 staff members supervising.</p> <p>V19 said I was present on 1/11/2025 when R21 fell outside while smoking. I was aware he fell on [DATE] outside while smoking but I was not present during this fall. R21 is in a wheelchair and has a habit of picking things up off the ground. V19 said I did not see R21 fall on 1/11/2025 but it is my understanding that he was in his wheelchair and reached down to grab his cigar. R21 fell out of his wheelchair and his face was on the concrete. I am not trained to transfer residents or evaluate them after a fall. I had to call nursing personnel and leave him in this position until someone came to assist.</p> <p>V19 said we should have as many staff supervising as we have residents in wheelchairs. It is difficult to push them outside, light their smoking material, and ensure they are being adequately supervised.</p> <p>On 2/5/25 at 10:59AM, V17 (Restorative Nurse/Fall Coordinator) said R21 admitted to us due to a mechanical fall at home. R21 was at risk for falls upon admission and requires assistance with his ADLs (activities of daily living). On 12/4/2024 at 9:00AM, R21 fell outside while smoking because he was trying to reach for his cigar that he had dropped on the ground. I provided him with a grab reacher to help assist R21 in grabbing things on the ground. However, R21 only uses this grab reacher in his room.</p> <p>V17 said on 1/11/25 at 4:00PM, R21 had another fall while outside smoking. He had dropped his cigar again and fell out of his wheelchair attempting to pick it up. He did not have his grab reacher with him at this time.</p> <p>V17 said I would have expected the staff to assist him when he dropped his cigar. It would not be appropriate for R21 to use his grab reacher to pick up his cigar, the staff should be providing him with assistance or a new cigar. V17 requires supervision when smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/5/25 at 11:42AM, V18 (Vice President of Operations) said my expectation would be that the staff are physically watching and monitoring residents for safety when they are smoking.</p> <p>R21's smoking assessment dated [DATE] states in part but not limited to the following: R21 requires assistance with smoking due to impaired cognition and requires a wheelchair for mobility. Resident is not considered a safe smoker and requires smoking management and supervision consistent with facility policy.</p> <p>Facility policy titled Smoking with revised date of 8/19/2024 states in part but not limited to the following: It is the facility's policy to monitor and assess residents that smoke to promote smoking in a safe manner. Those who are assessed as unsafe smoking will be provided supervision during smoking.</p> <p>Facility policy titled Fall Occurrence with revised date of 7/26/2024 states in part but not limited to the following: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary.</p>		