STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145339	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Elmhurst, The	127 West Diversey Elmhurst, IL 60126

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 33330 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by V3 (Agency CNA-Certified Nursing Assistant), when V3 punched R1 in the face and grabbed R1's lower arm. This applies to 1 of 4 residents (R1) reviewed for staff-to-resident abuse in the sample of 7. This failure resulted in R1 experiencing bruising on her face and lower arm and R1expericing a psychosocial impact. R1 stated she can still see V3's fist coming towards her face when she closes her eyes. The Immediate Jeopardy began on April 27, 2024, at 8:00 PM when V3 (Agency CNA) punched R1 in the face and grabbed R1's lower arm. V26 (Assistant Administrator), V25 (Vice President of Operations), and V19 (Regional Nurse Consultant) were notified of the Immediate Jeopardy on May 7, 2024, at 1:41 PM. The facility presented an abatement plan to remove the immediacy on May 7, 2024, at 2:16 PM, and the survey team accepted the abatement plan on May 7, 2024, at 2:59 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on May 7, 2024, at 2:16 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On April 30, 2024, at 11:09 AM, R1 was lying in bed in her room. R1 had dark purple bruising underneath her left eye, and dark purple bruising above her right eye in the crease between her eyelid and eyebrow. [NAME] bruising was also visible across the bridge of R1's nose, and fading, yellow bruising was visible on R1's left forearm from her wrist up towards her elbow, approximately four to six inches. R1 stated the bruising on her forearm happened after V3 (CNA) tightly grabbed her wrist and forearm on Saturday, April 27, 2024. R1 stated the bruising on her face, around her eyes and across her nose happened the same day, after she was punched in the face by V3 (CNA). R1 stated, It was Saturday, April 27, after dinner. I did not like the way [V3] (CNA) was trying to change me, and I told her to stop. Then she started using a pillow and was hitting me all over my body with it, over and over. I kept telling her to stop it. Then she used her big fist and punched me right in the face. [V3] grabbed my arms and left bruising on my left arm that is now going away. I said, Stop it! Stop it! Stop it! It was very scary. I have three roommates, but they do not talk and could not help me. I prefer to not talk about it because it was a bad thing, and I don't like to think about bad things. But every time I close my eyes, all I can see is her giant fist coming towards my face. I did not put on my call light because I was afraid to. Later, [V15] (LPN-Licensed Practical Nurse) came in to check on me. I asked her for pain medication because my face was hurting. She asked me what happened, and I told her [V3] (CNA) hit me. The EMR (Electronic Medical Record) shows R1 is a [AGE] year-old female who was admitted to the facility on [DATE]. R1 has multiple diagnoses including, thoracic and lumbosacral intervertebral disc disorder, pressure ulcer of the right buttock, reduced mobility, chronic kidney disease, chronic pain syndrome, diabetes, dementia, bipolar disorder, depression, congestive heart failure, COPD (Chronic Obstructive Pulmonary Disease), and history of transient ischemic attack and cerebral infarction. R1's MDS (Minimum Data Set) dated March 22, 2024, shows R1 is cognitively intact, requires set up assistance with eating, substantial/maximal assistance with oral hygiene, dressing, and bed mobility, and is dependent on facility staff for toilet hygiene, showering/bathing, personal hygiene, and transfers between surfaces. R1 has an indwelling urinary catheter and is always incontinent of stool. The EMR shows R1 has a care plan for being resistive to care, manifested by her depression and bipolar disorder diagnosis. The care plan was initiated on March 26, 2024. Multiple interventions initiated on March 26, 2024, show: Create a warm, safe, and inviting environment for care, make sure lighting is adequate, try to create a home-like bathroom/shower area. Emphasize dignity. Emphasize soothing, kind, slow, and compassionate speech. Do not rush or hurry. Use body language that communicates patience. On April 30, 2024, at 11:22 AM, V15 (LPN) stated, Around 7:45 PM, [R1] asked for her Tramadol (pain medication). V15 stated R1's Tramadol is scheduled to be administered at 9:00 PM. V15 stated I asked R1 why she needed pain medication early. She (R1) turned on her room light and was pointing to her right forehead, and I could see a bump and bluish discoloration around her right forehead, and she said [V3] (CNA) hit her. My whole body went cold because I have never had that happen, that someone said they were hurt by a staff member. The bruising was on her forehead, and I called [V1] (Administrator), the doctor, and the NP (Nurse Practitioner), and left a message for the family member. I then called the police, and the fire department. The paramedics came to the facility, but [R1] refused to go to the hospital and signed a paper to show she refused to go to the hospital. So, we did an X-ray. [R1] is a very particular resident about her care. She can be bossy. She is very alert. I sent [V3] (CNA) home right away. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On April 27, 2024, at 7:45 PM, V15 (LPN) documented, While making rounds, resident complained of pain on her forehead. Assessed complete body of resident. Resident noted right forehead bump with bluish discoloration of the skin. Skin intact in the surrounding area. When the resident was asked what happened, the resident said, The assigned CNA hit my face during ADLs (Activities of Daily Living). Ice pack applied to the site immediately. Neuro check started. No change in resident baseline mental status. Scheduled Tramadol given. Resident alert, oriented x/time 4 and verbally responsive. [V22] (Physician) and [V23] (NP) informed and ordered X-ray of the facial and nasal bones STAT. [V1] (Administrator informed. [V24] (Family member of R1) informed. Police were called and notified, with report number. Resident refused to go to the hospital to be checked even encouraged by NOD (Nurse on Duty) and the paramedics. Assigned CNA was sent home, pending investigation. Will continue to monitor resident. The facial and nasal bone X-ray dated April 27, 2024, showed: Normal X-ray examination of the nasal bones. Follow-up by CT/computerized tomography scan of the facial bones. On April 30, 2024, at 5:14 AM, V21 (NP) documented, Reason for visit: Comprehensive skin assessment. [R1] in bed. Awake, alert, and verbal. Noted to have ecchymosis surrounding around both of her eyes. When asked patient what happened to her eyes, she states, Oh that's something else. [R1] did not want to continue to talk about it. On May 1, 2024, at 10:41 AM, V1 (Administrator) stated, I was not able to speak to [V3] (CNA). On Monday, the detective came and told me that they found [V3] and there are approved charges to pick her up for aggravated battery. [V3] did not answer my calls. [R1] said [V3] came in to change her brief and [V3] pushed the resident on one side to remove the brief. [R1] told her she has a curved spine and when you put her in this position it hurts her. [R1] was trying to explain to [V3] how the other CNAs are able to do it, so it does not hurt her. When the CNA went around the other side and pushed her over in the bed, [R1] told [V3] I told you it hurts me how you are doing it. The CNA started hitting her with the pillow. [R1] said she did not scream out for help. [R1] said she was back onto her back and told [V3] (CNA) she was a bully and possibly called her a dummy and that is when [V3] (CNA) punched her. [R1] did not call anyone for help and it was not discovered until [V15] (LPN) was making rounds. [V15] found the injury and reported it to me right away and we sent the CNA home. On May 1, 2024, at 12:08 PM, V16 (Police Detective) said, I interviewed [V3] (CNA) on April 29, 2024, and she admitted to me that she punched [R1] and hit her with a pillow. She was charged with aggravated battery of a person 60 plus years old and she was taken to the county jail. On May 6, 2024, at 2:42 PM, V21 (NP) said she was asked to examine R1 on Tuesday, April 30, 2024, due to the abuse allegation. V21 found R1 to have bruising around both eyes which was not present on her last examination of R1 on April 25, 2024. V21 continued to say R1 can be particular about turning for wound and incontinence care and prefers to roll in bed on her own. If the CNA would have talked to her, [R1] would have told her how we turn her. We never turn her; she turns on her own. She has her way, and it works for her. She never complains of pain because she turns slowly on her own. She had to be punched right between her eyes to cause bruising on both eyes like that. It is fair to say the bruising around her eyes was caused by the punch. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Abuse Report Final Form, submitted to (the State Agency) on May 2, 2024, at 2:00 PM shows R1 as the alleged victim, and V3 (CNA) as the alleged perpetrator. The final report shows: A thorough investigation was conducted and physical abuse allegation against Agency CNA, namely [V3] has been substantiated. The facility's Abuse and Neglect Policy, effective date 7/14/23 shows: Policy Statement: 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 and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigations. 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: 1. Physical: Physical abuse includes but not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and roughly handling. The Immediate Jeopardy that began on April 27, 2024, at 8:00 PM was removed on May 7, 2024, at 2:16 PM when the facility took the following actions to remove the immediacy: R1 remains in the facility with psychosocial services available to R1. R1 was seen by a psychotherapist on May 3, 2024, and wellness checks by the Social Services Department have been ongoing from April 28, 2024, and will continue three times a week for 30 days. V3 (Agency CNA) was removed and placed on the do not return list on April 27, 2024, and has not returned to the facility since. Police were notified on April 27, 2024. On April 27, 2024, the facility notified the staffing agency that V3 was asked not to return due to an abuse allegation. On April 27, 2024, the facility opened an abuse allegation related to R1 and this investigation was concluded and substantiated. V3 (Agency CNA) was reported to the State Agency Healthcare Worker Registry on May 2, 2024. All agency staff will be provided abuse training prior to the start of their shift by the DON (Director of Nursing) or designee. This will include an audit questionnaire to validate return demonstration of understanding. Staff were re-educated on the facility Abuse and Neglect Policy by the Administrator and/or designee on April 30, 2024, and is ongoing. This re-education will continue and be completed by May 8, 2024. Return demonstration of understanding was provided by way of conducting an audit questionnaire. An audit was conducted on all residents cared for by V3 (Agency CNA) on March 24, 2024, March 30, 2024, April 11, 2024, April 21, 2024, and April 27, 2024, to ensure abuse did not occur with anyone else. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents with specific preferences and/or behaviors are being identified on May 7, 2024. Care cards listing these items will be placed in a binder at the nurse's station on each floor for staff knowledge. This will be updated as needed by the Social Services Department. This will be completed by May 8, 2024. All staff, including agency staff will be educated on the care card location, and to check the care card prior to providing care. This will be completed by May 8, 2024. Quality assurance audit will be conducted daily by the Administrator and/or designee to ensure agency staff have been educated on abuse with return demonstration of understanding. This will start on May 7, 2024, and continue for the first month. All identified trends will be reviewed by the monthly QAPI (Quality Assurance and Performance Improvement) Committee, and a plan will be discussed and implemented until resolution. The incident and abatement plan will be discussed and reviewed with the facility Medical Director on May 7, 2024, at 4:30 PM. Emergency QAPI meeting will be conducted on May 8, 2024, at 10:00 AM.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to ensure a resident was provided hand splints to prevent a resident's further decrease in range of motion as recommended by the Therapy Department. This applies to 1 of 3 residents (R4) reviewed for physical therapy in the sample of 6. The findings include: On April 30, 2024, at 9:25 AM, R4 was lying in bed in her room. R4 had a tracheostomy in place connected to a ventilator. R4 had a gastrostomy tube in place connected to tube feeding. R4's eyes were open. R4 did not respond to being spoken to or following commands such as raising her hands, blinking on command, or following movements across the room. R4 was not wearing hand splints. Intermittent observations were made of R4 on April 30, 2024, from 9:25 AM to 3:30 PM. R4 was not observed wearing hand splints during the observation period. On April 30, 2024, at approximately 3:15 PM, V18 (Restorative Nurse/LPN-Licensed Practical Nurse) said there was no restorative aide working all day, and the hand splints had not been placed on R4. On May 1, 2024, intermittent observations were made of R4 from 9:00 AM to 4:00 PM. R4 was not observed wearing hand splints during the observation period. The EMR (Electronic Medical Record) shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, traumatic subdural hemorrhage with loss of consciousness of unspecified duration, elevated white blood cell count, contracture of right upper arm muscle, tracheostomy, cervical disc degeneration, respiratory failure, anemia, encephalopathy, dependence on respirator, alcohol abuse, depression, history of falling, and gastrostomy tube. R4's MDS (Minimum Data Set) dated March 12, 2024, shows R4 is in a persistent vegetative state and has no discernable consciousness, is dependent on facility staff for all ADLs (Activities of Daily Living) and is always incontinent of bowel and bladder. R4's care plan for ADL self-care deficit and impaired mobility deficit related to physical inactivity, initiated April 4, 2024, shows: [R4] is on a splint and/or brace assistance program. Interventions initiated April 4, 2024, show: Restorative splint/brace program: Please provide/use assistance and supportive devices as needed (Specify: bilateral resting hand orthotics 6 hrs./day as tolerated . On April 30, 2024, at 2:50 PM, V20 (Director of Rehab) said, We screened [R4] for physical and occupational therapy. She was not able to participate in therapy due to her vegetative state. OT (Occupational Therapy) recommended she wear hand splints to prevent contractures and further decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Occupational Therapy Discharge Summary dated April 2, 2024, shows facility staff trained restorative staff to apply resting hand orthotics on R4, six hours per day to maintain R4's current level of function. The Discharge Summary continues to show R4's prognosis was good with consistent staff follow-through. R4's PT/OT (Physical Therapy/Occupational Therapy) Functional Maintenance Program sheet, dated April 4, 2024, shows: Splints: BUE (Bilateral Upper Extremity) resting hand orthotics 6 hours/day. For the period April 4 to April 30, 2024, the facility does not have documentation to show the bilateral hand orthotics were applied to R4 on the following dates: April 6, 7, 9, 10, 13, 15, 17, 18, 19, 20, 21, 22, 23, 25, 27, 30, 2024. On May 1, 2024, at 3:34 PM, V19 (Regional Nurse Consultant) said there was a glitch with how the CNA (Certified Nursing Assistant) task for applying R4's bilateral hand braces was entered into the computer, and nursing staff could not see R4 needed to wear the hand braces six hours daily. The facility's Restorative Nursing Program Policy revised 7/28/23 shows: Policy Statement: It is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Procedures: 1. Comprehensive Nursing and Restorative and Functional Assessment shall be completed on admission. 2. Appropriate nursing and restorative services consistent to the resident's functional needs must be provided. If the assessment shows the resident needs therapy, then therapy should be provided. 3. Nursing and Restorative Services may include the following: .c. Contracture prevention and management.ii. Splint/orthotic management. 4. Nursing and restorative services shall be reflected in the resident's individualized care plan consistent to the completion of the resident comprehensive assessment. 5. Evaluation as to the need of adaptive equipment/enabling devices to help accommodate the resident's needs, promote optimal functioning and self-sufficiency in ADLs may be referred to the Therapy Department (either physical and/or occupational therapy) for the most appropriate device/s recommendations. 6. Restorative Programs shall be reflected and indicated in the resident's electronic restorative log in order to document the provision of services and the frequency by the nurses, CNAs, and/or restorative aides .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to ensure a resident received scheduled pain medication as ordered. This applies to 1 of 3 residents (R4) reviewed for improper nursing care in the area of pain in the sample of 6. The findings include: On April 30, 2024, at 9:25 AM, R4 was lying in bed in her room. R4 had a tracheostomy in place connected to a ventilator. R4 had a gastrostomy tube in place connected to tube feeding. R4's eyes were open. R4 did not respond to being spoken to or following commands such as raising her hands, blinking on command, or following movements across the room. The EMR (Electronic Medical Record) shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, traumatic subdural hemorrhage with loss of consciousness of unspecified duration, elevated white blood cell count, contracture of right upper arm muscle, tracheostomy, cervical disc degeneration, respiratory failure, anemia, encephalopathy, dependence on respirator, alcohol abuse, depression, history of falling, and gastrostomy tube. R4's MDS (Minimum Data Set) dated March 12, 2024, shows R4 is in a persistent vegetative state and has no discernable consciousness, is dependent on facility staff for all ADLs (Activities of Daily Living) and is always incontinent of bowel and bladder. R4's care plan-initiated March 14, 2024, shows R4 is at risk for alteration in comfort level, pain related to complex medical conditions such as traumatic subdural hemorrhage. R4's care plan shows multiple interventions-initiated March 14, 2024, including, Administer pain medication per MD's order. The EMR shows the following order for R4 dated April 1, 2024: Norco (narcotic pain medication) oral tablet 5/325 mg. (milligrams). Give 1 tablet via G-Tube (Gastrostomy Tube) two times a day for moderate pain (pain 4-10). The EMR continues to show R4's Norco pain medication is scheduled to be administered daily at 9:00 AM and 9:00 PM. The facility does not have documentation to show R4 received the Norco pain medication at 9:00 PM on the following days: April 3, 4, 6, 11, 12, 13, 14, 15, 16, 19, and 26, 2024. R4's April 2024 MAR (Medication Administration Record), printed by the facility on May 1, 2024, at 2:22 PM shows the dates of April 3, 4, 6, 11, 12, 13, 14, 15, 16, 19, and 26, 2024 at 9:00 PM are blank and remained unsigned by facility staff indicating the Norco pain medication was not administered as ordered. The facility does not have nursing progress notes to show why nursing staff did not administer the Norco pain medication as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 29, 2024, at 1:53 PM, V17 (Daughter of R4) said she feels concerned that R4 is experiencing pain because she makes facial grimaces when she is touched by V17, or if V17 tries to comb R4's hair. On April 1, 2024, at 12:58 PM, V10 (NP-Nurse Practitioner) documented she examined R4 to follow up on reports by the nurse that R4 was experiencing tachycardia (rapid heart rate). V10 request an EKG (Electrocardiogram) be done on R4 and Norco to be started for assumed pain. On May 1, 2024, at 9:30 AM, V10 (NP) said, [R4's] EKG showed sinus tachycardia. I started her on Norco for pain, and also something for anxiety, thinking the fast heart rate was possibly caused by pain. Her heart rate at the time of the EKG was 117 beats per minute. [R4] is unable to tell us if she is having pain, is unable to ask for pain medication, and is unable to rate her level of pain, so that is why I ordered the medication to be administered twice a day instead of as needed. It is my expectation the nurses administer the pain medication as ordered. On May 1, 2024, at 3:34 PM, V2 (DON-Director of Nursing) presented copies of R4's April 2024 MAR and acknowledged the facility's nursing staff did not sign the MAR to show R4's Norco pain medication was administered as ordered. V2 continued to say the facility staff should remove the Norco from the locked narcotic box, document the removal of the medication on the narcotic count sheet, and document on the MAR when the medication is administered to the resident.