STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER: Grove of Elmhurst, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to obtain physician orders for resident medications to be at the bedside. The facility also failed to complete self-administration of medication assessments for residents. This applies to 4 of 4 residents (R62, R109, R21, R88) reviewed for medications in a sample of 30. The findings include: 1. On 4/2/24 at 10:23 AM, on R62's end table, the following medications were observed to be on top of his end table: Albuterol Sulfate Inhalation Aerosol HFA 90 MCG (Micrograms), Pulmicort flex inhaler 180 MCG, Tiotropium Bromide Inhalation Powder 18 MCG per capsule, and Mometasone Furoate nasal spray. R62 stated, They are always kept here. Nurses never take them back. I already know how to take them. A nurse never taught me. There's no need for that. R62's face sheet shows diagnoses of chronic obstructive pulmonary disease and asthma. R62's MDS (Minimum Data Set) dated 1/5/24 shows a BIMS (Brief Interview for Mental Status) score of 15, which means he is cognitively intact. R62's POS (Physician Order Sheet) shows orders for the above medications, but no orders for it to be at the bedside. R62's medical record was reviewed. There was no self-administration of medication assessment uploaded. 2. On 4/2/24 at 11:19 AM, R109 had a bag of medications on his end table. The medications included the following: Albuterol Sulfate Inhalation Aerosol HFA inhaler, Symbicort inhaler, Spiriva hand inhaler 18 MCG capsule, and Fluticasone Propionate. R109 stated, I have problems with my lungs. I keep these meds in this bag, which is always kept in my room. I know how to use these medications. No one showed me. The nurses never take it back. They are kept in my room. They never watch me when I take these meds. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R109's face sheet shows diagnoses of chronic obstructive pulmonary disease, malignant neoplasm of unspecified part of unspecified bronchus or lung, unspecified asthma, uncomplicated, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, personal history of pulmonary embolism, and dependence on supplemental oxygen. R109's MDS dated [DATE] shows a BIMS score of 14, which means he is cognitively intact. R109's POS shows orders for the above medications, but no orders for it to be at the bedside. R109's medical record was reviewed. There was no self-administration of medication assessment uploaded. 3. On 4/2/24 at 11:29 AM, R21 had Refresh Tears eye drops on her bed. R2 stated, This is in my room all the time. I put these in my eyes by myself. The nurse never does it. R21's MDS dated [DATE] shows a BIMS score of 15 which means she is cognitively intact. Review of R21's POS shows there is no order for the eye drops. R21's medical record did not have a self-administration of medication assessment uploaded. On 4/03/24 at 9:12 AM, V4 (LPN-Licensed Practical Nurse) stated, I think we only have one resident that can self-administer medications. If a resident's family bring meds, we have to consult the doctor and keep the meds until we get an ok from the doctor. We need to do a self-medication assessment form. The doctor has to sign it. We have to witness and see if it is clinically ok if the resident can take the medication by themselves. On 4/02/24 at 9:22 AM, V2 (DON) stated, The nurses should look those medications up and share them with the healthcare team. Nurses have to get an order from the doctor for the meds to be at the bedside and you have to do a self-administration of medication assessment which is uploaded into the (electronic medical record system). They are supposed to see medications are ingested and make sure they get all of them. No, we don't have self-administration of medication assessments for these residents. Facility's policy titled Self-Administration of Medication (7/8/23) shows the following: Procedures-1. The IDT (Interdisciplinary Team) will assign a staff to evaluate the resident's ability to safely administer medication. A Self-Administration Evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician order to keep it at bedside. 46003 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R88 currently located on the memory care unit. The EMR (Electronic Medical Record) show R88 was admitted to the facility on [DATE]. R88 has diagnoses that includes alcohol use, major depressive disorder, and anxiety. R88's MDS (Minimum Data Set) dated 2/6/24 shows R88 is cognitively intact with BIMS (Brief Interview for Mental Status) score of 14. On 4/02/24 at 11:33 AM, R88 had a round pale-yellow tablet, a small round white tablet, and a bottle of calcium carbonate 750mg (Milligrams) 140 counts on his bedside table. R88 was not sure but identified the yellow and white pills as thiamin and folic acid. On 4/02/24 at 11:45 AM, V31 RN (Registered Nurse) stated she had given R88 the pills and identified them as B1 and folic acid. On 4/03/24 at 4:38 PM, V2 DON (Director of Nursing) stated no residents on the memory care unit are assessed to self-administer medications because it would be unsafe and inappropriate for residents on a memory care unit. No assessment for self-administration of medications was found in R88's electronic medical record. R88 did not have a physician order for calcium carbonate.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46380 Based on observation, interview, and record review, the facility failed to ensure call lights were within residents' reach. This applies to 3 out of 3 residents (R2, R33 and R66) reviewed for call lights in the sample of 30. The findings include: 1. On 4/2/2024 at 10:21 AM, R2 was in bed and coloring a book. Call light was noted on the floor on the right side of her bed. R2 stated she uses the call light to call for help because she needs help with incontinent care and wants it to be accessible every time. R2 stated staff often forgets to put the call light where she can reach it. R2's MDS (Minimum Data Sheet) dated 1/17/2024 documents R2 has moderately impaired cognitive skills, has no impairment with upper extremities and is frequently incontinent of bowel. R2's Care plan dated 4/22/2024 documents R2 requires assistance with ADLs (Activities of Daily Living) with intervention to keep call light within reach. 2. On 4/2/2024 at 9:57 AM, R33 was in bed. Call light was not within reach and noted on her dresser on the right side of her bed. R33 stated she can use the call light and uses it when she needs help. R33 proceeded to demonstrate how she uses the call light but found out her call light was not within reach. R33 stated staff often forget to put it where she can reach it and must wait for staff to come to her room before she can be helped. R33 stated she likes the call light to be always within reach. R33's MDS dated [DATE] documents R33 has moderately impaired cognitive skills and has no impairment with upper extremities. R33's ADL care plan dated 3/4/2024 documents that she has a self-care deficit with intervention I would like staff to place call light within accessible reach. 3. On 4/2/2024 at 10:24 AM, R66 was in bed and watching television. Call light was noted on the floor on the right side of her bed. R66 stated she uses the call light to ask for help and wants it to be within reach, but staff do not always put the call light where she can reach it. R66's MDS date 3/22/2024 documents she has intact cognitive functions, has no impairment of upper extremities and is always incontinent of bowel and bladder. R66's ADL care plan does not include intervention to make call light accessible. On 4/4/2024 at 2:30 PM, V2 (DON-Director of Nursing) stated call lights should always be within reach so they can inform staff of need. V2 stated if call lights are not within reach, prompt incontinence care cannot be provided, and residents will try to do things on their own and might fall. Facility's Call Light Policy dated 10/26/2016 and revised on 7/27/2023 states the following: .Procedures: .5. Be sure call lights are placed within reach of resident who are able to use it at all times.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48944 Based on observation, interview, and record review the facility failed to ensure intravenous medications were administered by qualified staff. This applies to 5 of 5 residents (R24, R95, R476, R477, and R478) reviewed for intravenous therapy in a sample of 30. The findings include: 1. On 4/03/2024 at 9:09 AM, V24 (Agency Licensed Practical Nurse/LPN) reconstituted and administered R477's Micafungin IV (intravenous) medication through her right upper arm midline (long peripheral catheter) with the use of a dial flow drip regulator. R477's Order Review Report dated 4/03/2024 showed an order for Micafungin Sodium Intravenous Solution Reconstituted 100 MG Use 100 ml intravenously one time a day for Infection for 20 days and RUE Midline single lumen (non-valved)-Flush lumen with 10 ML 0.9% NS before & after antibiotic infusion. R477's MAR (Medication Administration Record) for April 2024 showed V24 (Agency LPN) administered three doses of the Micafungin IV medication. 2. On 4/03/2024 at 3:26 PM, V24 (Agency LPN) stated she routinely works on the same unit and frequently administers intravenous medications without supervision to her assigned residents, including R24, R95, R476, R477, and R478. R24's Order Review Report dated 4/03/2024 showed an order for Meropenem Intravenous Solution Reconstituted 1 GM Use 1 gram intravenously every 8 hours for leukocytosis for 7 days and RUE Midline single lumen (non-valved)-Flush lumen with 10 ML 0.9% NS before & after antibiotic infusion. R24's MAR for April 2024 showed V24 administered one dose of the Meropenem IV medication. 3. R95's Order Review Report dated 4/03/2024 showed an order for Cefepime HCl Solution 2 GM/100ML Use 2 gram intravenously every 8 hours for infection, leukocytosis for 7 Days previously tolerated cefepime and RUE Midline single lumen (non-valved)-Flush lumen with 10 ML 0.9% NS before & after antibiotic infusion. R95's MAR for April 2024 showed V24 and V37 (Agency LPN) administered four doses of the Cefepime IV medication. 4. R476's Order Review Report dated 4/03/2024 showed an order for Cefiderocol Sulfate Tosylate Intravenous Solution Reconstituted Use 1.5 gram intravenously every 8 hours for Intraabdominal infection for 14 Days and RUE Midline single lumen (non-valved)-Flush lumen with 10 ML 0.9% NS before & after antibiotic infusion. R476's MAR for April 2024 showed V24 and V37 administered five doses of the Cefiderocol IV medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R478' Order Review Report dated 4/03/2024 showed an order for Meropenem Intravenous Solution Reconstituted 500 MG Use 500 mg intravenously every 6 hours for leukocytosis for 7 Days and Zyvox Intravenous Solution 600 MG/300ML Use 600 mg intravenously two times a day for leukocytosis for 7 Days. R478's report did not show an order for an IV access. R478's MAR for April 2024 showed V24 and V37 administered four doses of the Meropenem and Zyvox IV medications. On 4/03/2024 at 4:36 PM, V2 (Director of Nursing/DON) stated LPNs should not be administering IV medications because it is outside of their scope of practice, only RNs (registered nurses) should be administering IV medications. The facility's document titled Job Description: Licensed Practical Nurse with an update date of 8/24/2018, showed Essential Functions 5. Administer medications within the scope of practice of the L.P.N. licensure. The document did not show the function of administering IV medications. The National Library of Medicine article titled Nursing Advance Skills dated 2023 said a midline is a long and deep peripheral catheter inserted in the veins of the upper arms, not a short intravenous catheter inserted by a percutaneous venipuncture into a peripheral vein. The Illinois Nurses Act (section 1330.240) amended on June 14, 2019, shows the scope of practice for LPNs which does not include initiating the administration of IV medications through a midline (long peripheral catheter) or reconstituting IV antibiotic medication solutions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed to provide incontinence care and respond to call lights in a timely manner. This applies to 8 of 8 residents (R11, R19, R40, R50, R56, R92, R99 and R105) reviewed for incontinence care in a sample of 30 residents. Findings include: 1. R99 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R99 was admitted to the facility on [DATE]. R99 has diagnoses that includes dementia, anxiety, and chronic kidney disease. R99's physician orders include 1500 ml (Milliliter) fluid restriction in 24 hours. R99's care plan dated 3/11/24 states he has extensive care needs and requires the support services of the long-term care setting. R99 has the potential for impaired skin integrity related to fragile skin, impaired mobility, occasional incontinence of bowel and bladder, medical diagnosis of dementia chronic kidney disease, essential tremors, and use of diuretics. Interventions include to keep skin clean and dry. R99 is at risk for alteration of bowel and bladder functioning and needs assistance with toileting. Intervention includes to remind and offer assistance with toileting as needed. R99 MDS (Minimum Data Set) dated 3/1/24 shows he is severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 1. On 4/02/24 at 10:08 AM, during room observation V32 CNA (Certified Nursing Assistant) was observed providing incontinence care to R99. R99 was wearing two disposable briefs. Both briefs were saturated with urine. 2. R11 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R11 was admitted to the facility on [DATE]. R11 has diagnoses that includes dementia, left hemiplegia / hemiparesis, major depressive disorder, and epilepsy. R11's care plan dated 2/26/24 includes a potential impairment to skin integrity related to fragile skin, impaired functional mobility, incontinence, history of pressure ulcer and medical diagnosis. Interventions include to keep skin clean and dry. R11 displays total bladder and bowel incontinence related to activity intolerance, confusion, dementia, impaired mobility, medication side effects and physical limitations. Interventions include to check resident for incontinence episodes. R11's MDS dated [DATE] shows moderate cognitive impairment with a BIMS score of 10. On 4/02/24 at 10:08 AM, during room observation V32 CNA removed a urine saturated brief from R11. R11's bed sheet was wet urine from his lower back to his knees. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R105 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R105 was admitted to the facility on [DATE]. R105 has medical diagnoses that includes left hemiplegia / hemiparesis following a cerebral infarction and muscle contracture. R105's physician orders include to cleanse perineal / buttocks area with soap and water and apply barrier cream after each incontinent episode. The care plan dated 3/5/24, R105 has potential impairment to skin integrity related to complex medical conditions such as history of skin tears, lacerations, pressure injury, incontinence, altered mobility function and fragile skin. Interventions include to keep skin clean and dry. R105's MDS dated [DATE] did not provide a BIMS score as R105 as he is rarely / never understood. R105 is severely cognitively impaired. R105 is completely dependent on staff for all his ADLs (Activity of Daily Living). On 4/02/24 at 10:36 AM, V32 (CNA). removed R105's disposable brief that was saturated with urine. The green positioning pad and bed sheet were also soaked with urine. 4. R50 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R50 was admitted to the facility on [DATE]. R50 has diagnoses that includes dementia and major depressive disorder. The care plan date 2/15/25, R50 has a potential impairment to skin related to fragile skin, poor skin turgor, functional limitations, incontinence of bowel and bladder, restlessness, agitation, and impaired cognitive ability. Interventions include to keep skin clean and dry. R50 has an ADL self-care performance deficit and impaired mobility related to decreased mobility, sepsis, type 2 diabetes, dementia, dysphagia, heart failure, depression, severe protein calorie malnutrition and macular degeneration. Interventions includes R50 requires total assistance personal hygiene and care. R50's MDS dated [DATE] documents sever cognitive impairment. On 4/02/24 at 11:06 AM, R50 received incontinence care assistance from V32 and V33 (CNAs). R50's disposable brief was saturated with urine through to the bottom bed sheet. R50 had dried stool on her buttocks. On 4/02/24 at 10:08 AM, V32 (CNA) stated her shift started at 7AM. V32 (CNA) stated residents should not have two incontinence briefs on them. V32 (CNA) denied placing two briefs on the residents and stated that was the first-time providing incontinence care to R11, R99 and R105. On 4/02/24 at 11:06 AM, V33 (CNA) stated she did not know R50 but was told to come to provide incontinence care and get her up. On 4/03/24 at 04:38 PM, V2 DON (Director of Nursing) stated C.N.A.s should not place two disposable briefs on residents. Residents should only wear on brief. If a resident is a heavy wetter or urinates frequently, they need to be toileted or changed more frequently. Leaving residents in soiled undergarments is not good for their skin and can contribute to skin break down. The resident had not been frequently enough if urine soaked through two disposable briefs. Residents aren't being changed frequently enough if it soaks through to their bedding. The facility General Care policy dated 7/28/23 states it is the facility's policy to provide care for every resident to meet their needs. The facility Incontinence and Perineal Care policy dated 7/28/23 states it is the policy of the facility to provide care to ensure cleanliness and comfort to the resident to prevent infection and skin irritation and to observe the resident's skin condition. 35267 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R19's MDS (Minimum Data Set), dated 3/4/24, shows R19 was always incontinent of urine, occasionally incontinent of bowel, and required maximum assistance for toileting and hygiene, and partial / moderate assistance for transferring on/off the toilet. R40's MDS, dated [DATE], shows R40 was always incontinent of urine and frequently incontinent of bowel. The MDS shows R40 required substantial/maximum assistance for toileting and hygiene. R40 required partial/moderate assistance from staff for toilet transfers. R56's MDS, dated [DATE], shows R56 was occasionally incontinent of urine and frequently incontinent of bowel. R56 required partial to moderate assistance from staff for toilet transfers. R92's MDS, dated [DATE], shows R92 was always incontinent of bowel/bladder and dependent on staff for toileting and hygiene. On 4/3/24 at 10:30 AM during Resident Council Meeting interviews, R19, R40, R56 and R92 all stated they felt agency CNAs (Certified Nursing Assistants) were not meeting their ADL (Activities of Daily Living) needs. The resident stated when they needed assistance with toileting, the CNA response to their requests was very slow. The residents stated the response from agency staff to their requests for toileting assistance was especially slow on the 3 PM -11 PM shift when most CNAs were agency CNAs. R56 stated the CNAs all seem to go on break between 6:00 PM and 8;00 PM at the same time and no staff are assigned to cover rooms while the CNAs are on break. R56 stated when all of the CNAs are on break, the residents are not able to get any assistance when needed and they are told to wait until the CNAs come back from break. R19 stated one of her roommates waited 2.5 hours for assistance to be toileted and urinated on herself waiting for staff to come assist her. On 4/3/24 at 11:50 AM, V34 (Ombudsman) stated she had resident complaints about staff not performing ADL care on the 11-7 shift for some time and did speak to administration about providing some type of supervision overnight to ensure care of the residents which had not yet happened. Resident council meeting minutes, dated 3/8/24, show, Residents report concerns for the following regarding agency 11-7 AM nurse staffing. Concerns regarding nurses leaving the units for extended period of time, residents in room [ROOM NUMBER] not being changed frequently enough or their liking ., minimal water pass and call lights not being attended for lengthy period of time. Resident council meeting minutes, dated 1/21/24, shows residents expressed concerns the evening CNAs overstay their lunch break and leave early without finishing their duties. Resident council meeting minutes. dated 2/9/24, show residents requested agency staff be inserviced and trained before starting their shifts to better assist the residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on interview and record review, the facility failed to have the required documentation in the medical record of residents who had pacemakers. This applies to 2 of 4 residents (R86, R91) reviewed for pacemakers in a sample of 30. The findings include: 1. On 04/02/24 11:45 AM, R91 was lying in bed. R91 was nonverbal, had a tracheostomy and was on a ventilator. R91's face sheet shows diagnoses of essential hypertension, paroxysmal atrial fibrillation, heart failure and presence of cardiac pacemaker. R91's POS (Physician Order Sheet) does not show an order for pacemaker. It does not show parameters on how often to check the pacemaker. R91's MDS (Minimum Data Set) dated 3/11/24 under Section C-Cognitive Patterns shows a blank score under BIMS (Brief Interview for Mental Status) and he scored a 3 under cognitive skills for daily decision making, which means he is severely impaired. R91's Admission assessment dated [DATE] shows that the nurse checked under the cardiac section that R90 did not have a pacemaker, when in fact R91 has a pacemaker inserted. R91's care plan (3/5/24) shows he has a pacemaker related to atrial fibrillation. Interventions include Check and document in chart as ordered: Heart Rate, Rhythm, Battery check. Check function upon admission/readmission and every 3 to 6 months in accordance to physician's order and facility policy. Review of R91's progress notes and care plans do not mention anything about the model, make, serial number of the pacemaker, date of insertion and the place it was inserted. Nothing is mentioned as when it was last checked and who should be checking it. On 4/3/24 at 1:20 PM, V2 (DON-Director of Nursing) stated, The nurse that's doing the admission is responsible for getting information regarding the pacemaker. If the patient doesn't have that information, then the nurse has to get the information from the POA (Power of Attorney) or the hospital. You also have to obtain orders from the physician to see how often it should be checked and it should be on the POS. The care plan should have the model number and serial number of the pacemaker. It should also have the company's phone number. 46380 2. On 4/2/2024 at 10:37 AM, a remote monitoring device for pacemaker was noted on R86's dresser. R86 stated he has a pacemaker and has only been checked once since he was admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R86's face sheet shows he was admitted to the facility on [DATE] with diagnoses of chronic systolic congestive heart failure, essential hypertension, atherosclerotic heart disease and presence of cardiac pacemaker. R86's POS dated 2/13/2024 shows an order that he may have pacemaker check per facility protocol. R86's Admission assessment dated [DATE] shows that he has a pacemaker but did not list type, manufacturer, and serial number. On 4/2/2024 at 11:00 AM, quick review of R86's care plan shows he has a pacemaker that does not specify the make, model, and serial number of the pacemaker. Intervention included check and document in chart as ordered: Heart Rate, Rhythm, Battery check. Review of R86's progress notes do not mention anything about the model, make, serial number of the pacemaker, date of insertion and the place it was inserted. Facility's Policy on Pacemakers dated 12/3/2015 and reviewed on 7/28/2023 stated the following: . Procedures:1. Residents who have pacemakers must have the following documented in their medical record: a. The date of insertion, physician who inserted it, and the place where it was inserted. B. Make, model and serial number of the pacemaker. C. Orders in the POS (physician order sheet) for how often the pacemaker is to be checked and by whom (physician office, cardiology clinic, by telephone, etc.). 2. The pacemaker remote follow-up/check should be done every 3-12 months or depending on the physician's orders.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to identify, report, assess, and obtain physician orders for new skin breakdown; failed to ensure treatment dressings were in place, soiled dressings were changed for residents with stage 3 and stage 4 pressure ulcers; and failed to implement pressure ulcer interventions. As a result of these failures, R41 had an unidentified right ischium wound with 25% necrotic tissue that was uncovered with no treatment; R24 had a right ischium wound with necrotic muscle tissue exposed with no treatment; and R18 had a right ischium wound with no treatment that increased in size from previous assessments. This applies to 5 of 5 residents (R9, R18, R24, R41, and R66) reviewed for pressure ulcers in a sample of 30. The findings include: 1. The EMR (Electronic Medical Record) showed R41 admitted to the facility on [DATE] with multiple diagnoses including multiple pressure ulcer stage, diabetes type 2, nutritional deficit, and tracheostomy dependent on a respiratory ventilator. The MDS (Minimum Data Set) dated 3/19/2024 showed R41 was cognitively impaired and was dependent on facility staff for ADLs (activities of daily living). The MDS continued to show R41 was at risk for developing pressure ulcers because R41 had multiple unhealed stage 3 and unstageable pressure ulcers. On 4/02/2024 at 10:21 AM, R41 was in bed. V11 (Wound Care Nurse/WCN) and V27 (Certified Nurse Assistant/CNA) turned R41 to perform wound care. R41 was soiled with stool and his left ischium dressing was saturated with yellow drainage and had an open wound to his right ischium without a treatment dressing in place. V11 stated R41's left ischium dressing was soiled from the wound drainage. V11 cleaned the stool off the right ischium wound and said it was her first time seeing the wound, V11 stated the wound had 25% necrotic tissue and the rest was granulation tissue and it appeared like a stage 3 pressure ulcer. V11 continued to remove the soiled dressing then cleansed the wound and applied new treatment dressings to R41's wounds. V11 continued to say she needed to have the Wound NP (Nurse Practitioner) assess the new wound before staging it. Then R41's left corner bed sheet had blood stains and the surveyor asked V11 to assess R41's left foot. R41's left heel was covered with a white island dressing dated 4/03/2024. V11 stated she had never seen the wound before, and she removed the dressing and said it had a medihoney dressing covering the wound bed. V11 then cleaned the wound and it started to bleed, V11 stated the wound bed had 100% slough tissue. V11 stated she had to ask the Wound NP to also assess and measure R41's new left heel wound. R41's Order Review Report dated 4/04/2024 showed an order for Left Ischium-Cleanse area with normal saline, apply collagen and calcium alginate and cover with dry dressing as needed and every day shift for treatment; and Right lateral lower leg: Cleanse with NSS, apply skin prep, and leave open to air as needed AND every day shift every Tue, Thu, Sun for Skin Alteration. The order report did not show a treatment order for the left heel and right ischium. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R41's Skin and Wound Note from the NP dated 4/02/2024 showed R41's left ischium stage 3 pressure ulcer measured 4.2cm x 3cm x 0.5cm with undermining from 11-1 o'clock measuring 1cm with a heavy amount of serosanguineous exudate and right lateral lower leg stage 3 pressure ulcer measured 1cm x 0.5cm x 0.1cm. R41's Skin and Wound Note from the NP dated 4/04/2024 showed R41 had a facility-acquired right ischium stage 3 pressure that reopened measuring 2.5cm x 1cm x 0.1cm and a new diabetic foot ulcer with partial thickness skin loss measuring 1cm x 1.8cm x 0.1cm with scant amount of serosanguineous exudate. On 4/05/2024 at 11:17 AM, V11 (WCN) stated the Wound NP assessed R41's new wounds, V11 continued to say R41's right ischium was a reopened stage 3 pressure ulcer, and the left heel was classified as a diabetic ulcer. V11 stated they could not determine the etiology of R41's left heel wound, and they looked at R41's diagnoses to help them classify the wound and made an educated guess. V11 said she was not able to find out who applied a dressing to R41's left heel wound or when it was identified. V11 stated when a new skin alteration is identified nurses should assess it, report to the Wound NP or primary physician to get treatment orders, update the family, and document it in the chart. 2. The EMR showed R24 admitted to the facility on [DATE] with multiple diagnoses including pressure ulcers stage 4, multiple sclerosis, tracheostomy dependent on respiratory ventilator, muscle wasting and atrophy, and malnutrition. The MDS dated [DATE] showed R24 was cognitively impaired and was dependent on facility staff for ADLs. The MDS continued to show R24 was at risk for developing pressure ulcers because R24 had two unhealed stage 4 pressure ulcers present on admission. On 4/02/2024 at 10:50 AM, R24 was in bed. V11 (WCN) and V27 (CNA) turned R24 to perform wound care. R24's sacrum and left ischium dressings had a foul odor and were saturated, the drainage seeped into the incontinence pad underneath. R24's right ischium was observed without a treatment dressing in place and had necrotic muscle tissue exposed. V11 removed the soiled dressings then cleansed the wounds and applied new treatment dressings. V11 said R24's wounds should have been covered and if the dressing were soiled, they should have been changed. V11 said she expected the floor nurses to cover the wounds as ordered because the wounds could deteriorate. R24's Care Plan dated 4/04/2024 showed R24 had actual impaired skin integrity to his sacrum a stage 4 pressure ulcer, left ischium stage 4 pressure ulcer, and right ischium unstageable initiated on 2/09/2024. R24's Order Review Report dated 4/04/2024 showed an order for Medihoney Ca Alginate 4x5 External Pad Apply to left ischium topically as needed for treatment. Apply to left ischium topically every day shift for treatment. Cleanse wound with normal saline, apply medihoney + calcium alginate and cover with dry dressing; Right ischium: Cleanse with NSS, apply Medihoney, and cover with bordered gauze as needed and every day shift every Tues, Thu, Sun for Skin Alteration; and Sacrum: Cleanse with NSS, apply hydrogel and silver alginate, and cover with bordered foam as needed for Skin Alteration and every day shift for Skin Alteration. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R24's Skin and Wound Note from the NP dated 4/02/2024 showed R24's sacrum stage 4 pressure ulcer measured 12cm x 17cm x 1.5cm with undermining from 10-11 o'clock measured at 1.8 cm and with fragile peri-wound and heavy amount of serosanguineous exudate, left ischium stage 4 pressure ulcer measured 5.4cm x 4cm x 2.3cm with tunneling at 12 o'clock measured at 5.3cm and with a moderate amount of serosanguineous exudate, and right ischium stage 4 pressure ulcer measured 6.2cm x 6cm x 0.8cm with exposed tendon/ligament and a moderate amount of serosanguineous exudate. R24's initial Skin and Wound Note from the NP dated 2/13/2024 showed R24's sacrum stage 4 pressure ulcer measured 7.5cm x 7.5cm x 1cm with no undermining with a moderate amount of serosanguineous exudate and left ischium stage 4 pressure ulcer measured 6.5cm x 3cm x 1cm with no tunneling and with a moderate amount of serosanguineous exudate. The note did not show any assessment for R24's right ischium stage 4. R24's Skin and Wound Note from the NP dated 2/15/2024 showed R24's had a new right ischium wound classified as MASD (Moisture Associated Skin Damage) measuring 0cm x 0cm x 0cm with a scant amount of serosanguineous exudate. On 4/05/2024 at 11:17 AM, V11 (WCN) stated R24's right ischium stage 4 pressure wound was acquired a few months ago as a DTI (deep tissue injury) and then progressed as an unstageable. V11 said the initial assessment was done by the Wound NP, she believes it was found during their wound rounds. 3. The EMR showed R18 admitted to the facility on [DATE] with multiple diagnoses including pressure ulcer stage 4, quadriplegia, tracheostomy dependent on respiratory ventilator, and malnutrition. R18's MDS dated [DATE] showed R18 was cognitively intact and was dependent on facility staff for ADLs. The MDS continued to show R18 was at risk for developing pressure ulcers because R18 had an unhealed facility-acquired stage 4 pressure ulcer. On 4/02/2024 at 10:04 AM, R18 was in bed. V11 (Wound Care Nurse/WCN) and V27 (Certified Nurse Assistant/CNA) turned R18 to perform wound care. R18's right ischium pressure ulcer was observed without a treatment dressing in place and was soiled with stool. V11 cleaned the stool off the wound and said there should have been a dressing covering the wound as ordered. R18's Order Review Report dated 4/04/2024 showed an order for Right ischium: Cleanse with NSS, apply collagen, and secure with border gauze as needed for Skin Alteration and every day shift every Tues, Thu, Sat for Skin alteration. R18's Skin and Wound Note from the NP dated 4/02/2024 showed R18's right ischium stage 4 pressure ulcer measured 4.5 cm x 4 cm x 0.1 cm. R18's initial Skin and Wound Note from the NP dated 7/25/2023 showed R18's right posterior upper thigh (right ischium area) had a partial thickness wound measuring 3 cm x 0.8 cm x 0.01cm classified as a skin tear/laceration. R18's TAR (Treatment Administration Record) for April 2024 showed R18 received wound care to her right ischium pressure wound once on 2/02/2024 by V11. On 4/04/2024 at 11:41 AM, V2 (Director of Nursing/DON) stated she expected the nurses to change dressings when needed and not wait for the WCN. V2 stated each floor had wound care supplies if needed. V2 stated the Wound NP is the one measuring and assessing the facility wounds and notifies her of any changes when she rounds at the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	46380 4. On 4/2/2024 at 10:03 AM, while V6 (CNA-Certified Nurse Assistant) and V7 (CNA) were providing incontinence care to R9, it was noted that R9 did not have any wound dressing on her sacral wound. V6 stated it was the first time during her shift (7 AM to 3 PM) that she was providing incontinence care to R9. V6 said it was reported that R9 was last changed around 6 AM. After incontinence care was done, V6 applied incontinent briefs and said she will inform the nurse and the wound care nurse that R9 needed new wound dressing. On 4/2/2024 at 11:54 AM, skin check was done with V6. R9 still had no wound dressing on her stage four pressure ulcer on her sacrum. On 4/2/2024 at 1:06 PM, V11 (Wound Care Nurse) stated she has not been to the third floor to do wound dressings. V11 denied being informed that R9 had no wound dressing for the entire morning. V11 stated R9 had a stage 4 on her sacrum. V11 stated there should always be a wound dressing to prevent the wound from being exposed to urine and feces. V11 stated the dressing also is needed for wound healing. V11 said if there is no wound dressing, the wound has potential for infection and the wound may become worse. On 4/3/2024 at 9:05 AM, R9's back and buttocks were soaked with fluid coming out from her feeding tube machine. V6 CNA stated V13 (RN-Registered Nurse) informed her at 9:00 AM that R9 needed to be changed because she was soaked. While V6 and V12 (CNA) were providing care, R9's wound dressing on her sacrum was peeled off due to moisture. The wound appeared macerated with wound edges appearing whitish from being soaked in fluid. On 4/3/2024 at 9:06 AM, V13 stated she did not touch R9's feeding tube. V13 stated the last time the feeding tube was touched was when R9 received her medications around anywhere from 5:00 AM to 7:00 AM. She said fluid seeped out because the valve was not properly clamped. She said she discovered R9 was soaked and informed V6 right away. On 4/3/2024 at 10:37 AM, V13 measured R9's sacral wound. Measurement was 3.8 cm (centimeters) width x 4.9 cm length x 0.3 cm depth. She said the wound edges appeared macerated and fragile. R9's face sheet documents she was admitted to facility on 10/3/2022. Diagnoses include hemiplegia, hemiparesis, Alzheimer's disease, aphasia, and dysphagia. R9's MDS (Minimum Data Sheet) documents R9 has severely impaired cognitive functions and is dependent on staff for ADLs (Activities of Daily Living). R9's POS (Physician Order Sheet) dated 3/8/2024 has an order to cleanse sacral wound with normal saline, apply xerofoam, and cover with dry dressing every day shift every Tuesday, Thursday, Saturday and as needed. R9's care plan dated 1/3/2024 shows wound care plan has interventions to follow facility protocols for treatment of injury and to keep skin clean and dry. R9's wound assessment done on 3/28/2024 shows sacral wound measured 4 cm width x 4 cm length x 0.10 cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5. On 4/3/2024 at 10:07 AM, V11, Wound Care Nurse did a skin check on R66. V11 stated R66 had no open areas and skin is being protected with moisture barrier. When R66's incontinence briefs were removed, she turned R66 to her left side, open wounds were noted on her left and right buttocks. V11 did not assess the wounds and did not measure the wounds. V11 applied hydrocolloid dressing to wounds on left buttock and right buttock. V1 said Wound Nurse Practitioner will be in the facility tomorrow. R66's face sheet documents she was admitted to facility on 10/12/2022. Diagnoses includes thoracic, thoracolumbar, and lumbosacral intervertebral disc order, hypertension, dementia, and type II diabetes mellitus. R66's MDS documents she has intact cognitive functions, is always incontinent of bowel and bladder and needs extensive assist from staff for turning and repositioning in bed. R66's Wound Assessment Report dated 3/28/2024 documents wound on right buttock and sacrum were resolved. R66's POS shows there was no treatment order received for her wounds on left and right buttocks on 4/3/2024 when the wounds were discovered. Review of R66's Progress Notes show no notes were recorded on 4/3/2024 regarding the wounds discovered on R66's right and left buttocks and informing physician of the new wounds. Last skin evaluation on R66 was done on 3/22/2024. On 4/4/2023 at 10:52 AM, V15 (Wound Nurse Practitioner) stated resident should not be sitting in moisture like urine or feces or fluid from feeding tubes because there is a potential that resident will develop pressure ulcers or resident's pressure ulcer will deteriorate. V15 stated sitting in moisture could also cause infection and can make wound healing take longer. V15 stated if a resident's wound dressing is not applied, there is a potential for infection and potential for deterioration of the wound. V15 stated R9's sacral wound decline could be in part caused by not applying wound dressing and being soaked in liquid from the feeding tube. She said if wounds were discovered, she expects the nurses to assess the wound, measure the wound, document findings, and inform her about it. Facility Policy on Wound Care Guidelines dated 12/1/2015 and revised on 1/24/2024 stated the following: .3. Prevention of skin breakdown includes but not limited to: .c. Inspection of the skin every shift with care for signs of breakdown.e. Keeping local areas of skin clean, dry, and free of body wastes, perspiration, and wound drainage.4. Activity, Mobility, and Positioning .h. Keep the linens dry and wrinkle free.9. Documentation .d. The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers and etc .) shall be documented in the resident's clinical records in accordance with the facility's policy and in compliance to current regulatory standards. 10. Pressure Injuries Treatment .a. Initiate wound care treatment upon identification of the wound with physician's order.c. Timely referral to the facility's Wound Care Specialist for all pressure injuries and/or wounds.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to change a resident's midline catheter dressing, measure, and document the external length of the catheter and arm circumference per facility policy. This applies to 1 of 5 residents (R476) reviewed for midline catheters in a sample of 30. The findings include: The EMR (Electronic Medical Record) showed R476 was admitted to the facility on [DATE] with multiple diagnoses including intra-abdominal infection. R476's MDS (Minimum Data Set) dated 3/31/2024 showed he was receiving IV (intravenous) antibiotic treatment. On 4/02/2024 at 10:36 AM, R476 had an intravascular midline catheter to his right upper arm. R476's midline catheter had a transparent dressing dated 3/24/2024. On 4/04/2024 at 11:24 AM, R476 had the same transparent dressing dated 3/24/2024. R476's Order Review Report dated 4/03/2024, showed an order for RUE-right upper extremity Midline single lumen (non-valved)-cleanse with chlorhexidine and cover site with transparent dressing every day shift every Thu and as needed for soilage/dressing dislodgement, RUE Midline single lumen (non-valved)-measure arm circumference every day shift every Thu, and RUE Midline single lumen (non-valved)-measure external catheter length with each dressing change from exit site to 0 every day shift every Thu. R476's Treatment Administration Records for March and April 2024 did not show any documentation for R476's midline dressing change or measurements of the external catheter and arm circumference. On 4/04/2024 at 12:22 PM, V5 (IP/Infection Preventionist) stated midline catheter dressings should be changed every 7 days for infection control prevention. V5 stated R476's midline dressing was not changed because he went to the hospital and when he returned it was missed. The facility's Intravenous Therapy policy with a revised date of 8/07/2023, showed Procedures 2. Dressing Change: b. All midline catheter dressing are to be done every 7 days while following the procedure for dressing change of central lines. The extremity circumference will be measured weekly to monitor for edema . c. viii. Additionally, for PICC line, the length of the external catheter and extremity circumference will be measured weekly to monitor movement and edema .

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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 46003

Based on observation, interview, and record review the facility failed to immediately address a resident screaming in pain. This applies to 1 of 1 resident (R75) in a sample of 30 residents.

Findings include:

R75 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R75 was admitted to the facility on [DATE]. R75 has diagnoses that include congestive heart failure, anxiety, severe intellectual disabilities, schizoaffective disorder, and type 2 diabetes.

R75's physician orders include heel protectors, low air loss mattress and pain assessment every shift. Acetaminophen 650mg every six hours as needed for pain. The care plan dated 2/27/24, R75 is at risk for impairment to skin integrity and is at risk for further skin impairment related to fragile skin, impaired ADL (Activity of Daily Living) / mobility, incontinence, and history of pressure injury. R75 is at risk for pain related to chronic physical disability. Interventions include administer pain medication per Medical Doctors order. R75's nurse to evaluates the effectiveness of pain interventions every shift and as needed. R75 is to be monitored and record / report to the Nurse any signs / symptoms of non-verbal pain that includes changes in breathing, vocalizations (yelling out), mood / behavior, face, and body. The MDS (Minimum Data Set) dated 2/16/24 shows R75 is severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 5.

On 4/02/24 at 11:02 AM, R75 was heard continuously yelling and screaming from her room at end of hall.

On 4/02/24 at 11:24 AM, R75 was still continuously yelling and screaming from her room at end of hall.

On 4/02/24 at 12:12 PM, R75 was observed lying in bed screaming. Surveyor asked R75 why she was screaming. R75 pointed to the blue transfer sling she was lying on. R75 stated she wanted the sling removed because it was hurting her.

On 4/02/24 at 12:18 PM, V30 C.N.A. (Certified Nursing Assistant) stated she assisted V10 C.N.A. get R75 cleaned up around 11 AM and 11:30 AM. V30 stated she puts transfer slings under the resident just before she gets them up and does not leave residents on transfer sling. V30 removed the transfer sling.

On 4/02/24 at 12:21 PM, V10 C.N.A stated R75 was going to get up but she was screaming. V10 stated she could not go back to R75 because she had to assist passing the meal trays to other residents. V10 stated she had informed the Nurse to give R75 pain medication.

On 4/02/24 at 12:24 PM, V31 RN (Registered Nurse) was observed in the R75's hall when R75 had been yelling and screaming. V31 did not respond when asked did she hear R75 screaming. V31 stated R75 could have Acetaminophen for pain. V31 stated the last time R75 received Acetaminophen was 3/24/24.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/24 at 12:48 PM, V31 was observed administering medication through R75's feeding tube. V75 was no longer screaming and stated she felt better. On 4/03/24 at 4:38 PM V2 DON (Director of Nursing) stated if staff hear a resident screaming down the hall, they should check on them immediately. Staff should not leave a resident on transfer slings if they aren't actively being transferred. The slings are uncomfortable. The residents can have fragile skin that may become bruised or injured by the slings. The facility Pain policy dated 7/28/23 states it's the facility policy to ensure that all residents are assessed for pain in every situation where there is a potential for pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48944 Based on observation, interview, and record review the facility failed to dispose of controlled medications per facility policy. This applies to 3 of 3 residents (R4, R58, and R108) reviewed for controlled medications in a sample of 30. The findings include: 1. On 4/03/2024 at 2:53 PM, R58's lorazepam 0.5mg (milligrams) medication punch card was observed with the #3 pill slot punched open, with tape over it with a pill inside. R58's Order Review Report dated 4/03/2024 did not show any order for lorazepam. 2. On 4/03/2024 at 2:53 PM, R108's hydrocodone-APAP 5-325mg medication punch card was observed with the #9 pill slot punched open, with a band-aid over it with a pill inside. V25 (Registered Nurse/RN) was present during R58 and R108's observations and stated the medications should have been wasted appropriately and not placed back into the punch cards. R108's Order Review Report dated 4/03/2024 showed an order for Norco Oral Tablet 5-325 MG Give 1 tablet via G-Tube two times a day for pain. 3. On 4/03/2024 at 3:12 PM, R4's tramadol 50mg medication punch card was observed with the #1 pill slot punched open, with tape over it with a pill inside. V26 (RN) was present during the observation and stated the medication should have been wasted and the medication log updated. R4's Order Review Report dated 4/03/2024 showed an order for tramadol HCI Oral Tablet 50 MG Give 1 tablet by mouth every 12 hours as needed for Pain. On 4/03/2024 at 4:36 PM, V2 (Director of Nursing/DON) stated controlled medications should not be returned in the medication punch cards, they should be discarded appropriately and witnessed by 2 nurses. V2 continued to say discontinued controlled medications should be given to her for proper destruction. The facility's Medication Storage, Labeling, and Disposal policy with a revised date of 8/24/2023, showed 6. Controlled meds should be disposed of properly to prevent accidental exposure and diversion using Drub Buster or Rx Destroyer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Grove of Elmhurst, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39182 Based on observation, interview, and record review the facility failed to cleanse and sanitize hands to prevent cross contamination for 4 of 4 residents (R11, R93, R99, R105) reviewed for infection control in the sample of 30. Findings include: 1. On 4/3/24 at 10:54 AM, V21 (RT-Respiratory Therapist) entered the room of R93, did hand hygiene, wore clean gloves, and waited for the CNAs (Certified Nursing Assistants) to finish bathing R93. While waiting, V21 (RT) touched the bed and other surfaces in the vicinity. With the same gloves and no hand hygiene, V21 (RT) disconnected the nebulization medicine container from the trach tubing and placed it into a plastic bag. With the same gloves and no further hand hygiene, V21 (RT) removed the gauze around the tracheostomy of R93, which was wet with sputum and placed it on the bed of R93. With same gloves and no hand hygiene, V21 (RT) opened the bedside drawer and took out new pack of sterile gauze, sterile gloves, Trach tie and inner cannula. With same gloves and no hand hygiene, she opened the packet of the new tie and changed the tie on the outer cannula and removed the inner cannula. With the same gloves and no hand hygiene, V21 (RT) opened the sterile gauze packet and cleaned the tracheostomy area with gauze and placed the soiled gauze on the bed of R93. With same gloves and no hand hygiene, V21 (RT) opened the sterile gloves and wore the sterile gloves on top of the used gloves, changed inner cannula and applied new dressing. With same two pairs of gloves and no hand hygiene, V21 (RT) picked up all the soiled items from R93's bed and discarded into the trash can. With the same gloves and no hand hygiene, V21 (RT) opened the humidifier on the oxygen concentrator, picked up the sterile water bottle from the bedside table, filled up the humidifier to the desired level and replaced the bottle. Then, V21 (RT) removed both pairs of gloves, discarded them into trash can, used hand sanitizer and left room by 11:10 AM. On 4/3/24 at 11:12 AM, V21 (RT) stated she did not maintain sterile technique while changing the inner cannula of R93's tracheostomy. V21 (RT) stated, she should have discarded the used soiled gloves, done hand hygiene, and then should have worn the sterile gloves. V21 (RT) stated, she should not have opened the drawer with soiled gloves and taken out new packet of gloves, gauze, trach tie and inner cannula with soiled gloves and no hand hygiene. On 4/3/24 at 2:30 PM, V20 (DRT-Director of Respiratory Therapy) stated, V21(RT) should have followed hand hygiene and change of gloves before moving from work on soiled body site to a clean task. Also, that she should have followed sterile technique while changing the inner cannula. On 4/3/24 at 3:05 PM, V2 (DON-Director of Nursing) stated, not following principles of hand washing and appropriate change of gloves causes the resident to be at higher risk of infection. V2 (DON) stated she conducts in-services and competencies on hand hygiene for all staff of the facility every month and as needed. Facility policy on 'Hand Hygiene' dated 7/28/23 showed, ' .Hand hygiene is recommended . b. before and after performing aseptic task. g. before moving from work on soiled body site to a clean body site on the same resident. h. After contact with blood, . and body fluids.' (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46003 2. R99 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R99 was admitted to the facility on [DATE]. R99 has diagnoses that includes dementia, anxiety, and chronic kidney disease. R99's care plan dated 3/11/24 states he has extensive care needs and requires the support services of the long-term care setting. On 4/02/24 at 10:08 AM, during the room observation V32 (CNA--Certified Nursing Assistant) was observed providing incontinence care to R99. V32 threw the two-urine saturated disposable briefs on the floor. V32 with same soiled gloves went to the wardrobe and put one pair of clean briefs on R11's (R99's roommate) bed. V32 then picked the soiled briefs off the floor placed them in a plastic bag then threw the bag of soiled briefs on the floor. V32 then applied a clean brief to R99. V32 removed her soiled gloves and put on a new pair of gloves without performing hand hygiene. V32 went in bathroom to get wet towel to clean R99's roommate R11. 3. R11 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R11 was admitted to the facility on [DATE]. R11 has diagnoses that includes dementia, left hemiplegia / hemiparesis, major depressive disorder, and epilepsy. R11's care plan dated 2/26/24 show R11 has impaired immunity related to diagnosis of Human Immunodeficiency Virus and Hepatitis C. R11's MDS (Minimum Data Set) dated 2/24/24 shows moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 10. On 4/02/24 at 10:08 AM, during the room observation V32 (CNA) was observed providing incontinence care to R11. V32 picked the bag of urine-soaked brief belonging to R99 (R11's roommate) off the floor and placed it on the over bed table that was in use by R11. V32 then placed the urine-soaked brief in the garbage bag. V32 wiped R11's genitals and buttocks with the towel. V32 then placed a clean disposable brief on R11 and left the room. 4. R105 currently residing on the memory care unit. The EMR (Electronic Medical Record) shows R105 was admitted to the facility on [DATE]. R105 has medical diagnoses that includes left hemiplegia / hemiparesis following a cerebral infarction and muscle contracture. The MDS dated [DATE] did not provide a BIMS score as R105 as he is rarely / never understood. R105 is severely cognitively impaired. R105 is completely dependent on staff for all his ADLs (Activity of Daily Living). On 4/02/24 at 10:36 AM, V32 (CNA) came in the room with a clean disposable brief. V32 put on new gloves, moved the bag of urine-soaked briefs she had previously placed on R11's over bed table to the floor left of R105's bed. V32 placed the clean brief on R105 bed. V32 moved the over bed table against the wall at the foot of R11's (R105's roommate) bed. V32 moved a wheelchair to the left corner of R11's bed. V32 adjusted the privacy curtain between the two beds. V32 then removed her gloves leaving the room to retrieve more linen. V32 returned to the room and put on new gloves. V32 then returned to the room placing clean linen on the over bed table that she had previously placed the bag of soiled undergarments. V32 then moved the overbed table to the left of R105's bed. V32 then removed R105's urine-soaked brief. Using her gloved hands placed the soiled brief in the bag of other urine-soaked briefs. V32 then removed R105's urine-soaked bed linens placing in a green bag that she placed on the floor and throwing other linens directly on the floor. V32 CNA. then placed clean linen on the bed and a clean disposable brief on R105. V32 then picked up the green bag and other linens off the floor and placed them on the foot of R105's bed to bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/03/24 at 4:38 PM, V2 DON (Director of Nursing) stated CNAs should not place soiled undergarments and linen directly on the floor because of infection control concerns. Staff should not place bags of soiled undergarments on roommates overbed table. Soiled undergarments and linens should be taken to the laundry chutes and not inter-mixed from resident to resident because of infection control issues. Staff should be removing their gloves and performing hand hygiene appropriately because it is an infection control issue, and they could possibly spread contaminants to other residents. The facilities Infection Prevention and Control Policy dated 10/23/23 states hand hygiene will be performed by staff before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing for 20 seconds will be used. The facility will comply with infection control recommendations provided by IDPH or certified local health department, including measures designed to reduce incidence of infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 31327 Based on interview and record review, the facility failed to utilize a standardized tool to determine the necessity of antibiotics prescribed to residents. This applies to 4 of 4 residents (R32, R41, R121, R176) reviewed for antibiotics in a sample of 30. The findings include: On 4/3/24 at 11:30 AM, surveyor reviewed the infection control binder in the presence of V5 (Infection Preventionist/Registered Nurse/Assistant Director of Nursing). There were no McGeer's criteria forms for residents who were prescribed antibiotics within the last 3 months. V5 stated that he is covering for the previous infection preventionist because she is on vacation. V5 stated he will look in the computer to see if it was done. 1. R32's POS (Physician Order Sheet) shows an order for Levaquin Tablet 250 MG (Milligrams) (Levofloxacin)-Give 1 tablet by mouth one time a day for infection for 5 days (Start date of 3/31/24 with an end date of 4/5/24). There was no McGeer's criteria uploaded into her medical record. 2. R41's POS shows an order for Levofloxacin Intravenous Solution (Levofloxacin)-Use 750 MG intravenously one time a day for leukocytosis for 7 days (Start date of 3/27/24 with an end date of 4/3/24). There was no McGeer's criteria uploaded into his medical record. 3. R121's POS shows an order for Amoxicillin-Potassium Clavulanate Tablet 500-125 MG-Give 1 tablet by mouth three times a day for soft tissue infection for 7 days (Start date of 4/1/24 and end date of 4/8/24). There was no McGeer's criteria uploaded into his medical record. 4. R176's POS shows an order for Cefiderocol Sulfate Tosylate Intravenous Solution Reconstituted (Cefiderocol Sulfate Tosylate)-Use 1.5 gram intravenously every 8 hours for intra-abdominal infection for 14 days Dextrose 5% solution 100 ML (Milliliters) with Cefiderocol 1 gram solution 1.5 gram (Start date of 3/27/24 and end date of 4/10/24). There was no McGeer's criteria uploaded into his medical record. On 4/3/24 at 2:37 PM, V5 stated, I could not find the McGeer's criteria forms. We have not been utilizing the McGeer's criteria because we have a lot of agency nurses, and they are not doing this. The nurses should be doing this. I will work on this. So, at this time, it's a work in progress. V5 stated the facility did not have a policy regarding McGeer's criteria for antibiotics.