

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/25/2024
NAME OF PROVIDER OR SUPPLIER  Grove of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE  611 Allen Lane Saint Charles, IL 60174	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</b></p> <p>Based on observation, interview, and record review, the facility failed to investigate allegations of sexual abuse in a timely manner. The facility also failed to implement their Abuse policy and procedure and conduct a comprehensive investigation of the alleged sexual abuse and report the abuse to the state health department and police department.</p> <p>This applies to 1 of 5 residents (R5) reviewed for sexual abuse in a sample of 12.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) shows that R5, a [AGE] year-old with diagnoses of dementia in Alzheimer's disease, major depressive chronic pain, difficulty in walking, cognitive communication deficit, depressive disorder, autoimmune thyroiditis, osteoporosis, Lyme disease, hypothyroidism, anxiety disorder, hypertension, and spinal stenosis. R1 was admitted to the facility on [DATE].</p> <p>R5's MDS (Minimum Data Set) dated 8/5/2024, showed R1 had moderate cognitive impairment.</p> <p>The progress notes dated 8/16/2024 showed that R5 was sent to the hospital related to medication regimen to address R5's aggression.</p> <p>The hospital record dated 8/16/2024 showed that R5 was:</p> <p>- A patient admitted from (nursing facility) for increased aggression, refusing to take medications. History of depression. Upon examination, (R5) was alert and oriented times 3. States that they want me on antidepressant, and I am sensitive to medications and only requires low doses. Patient needs inpatient psychiatric hospitalization for mood stabilization and safety. The hospital record also showed that on 8/17/2024, R5 was transferred to the medical floor due to acute pulmonary embolism and acute DVT (deep vein thrombosis).</p> <p>On 8/20/2024 at 10:30 A.M., V1 (Administrator) said that on 8/16/2024, she had received a call from V15 (hospital staff) that R5 made an allegation of sexual abuse towards a male staff working in the facility. V1 said that she did not investigate this sexual allegation because there was an open allegation regarding R1's alleged physical abuse towards a CNA (Certified Nurse Assistant), that R1 felt being rushed on 8/15/2024 at 2:30 P.M. Surveyor verified with V1 if the allegation of being rushed is the same as sexual abuse. V1 then decided to initiate sexual allegation and called the police department.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/20/2024 at 11:30 A.M., V18 (Police Officer) came to the facility. V18 said that this case of sexual abuse was called in by the hospital on 8/16/2024 when R5 made the allegation. V18 said that it was today (8/20/2024) that the facility had notified the police department regarding the allegation of sexual abuse.</p> <p>On 8/21/2024 at 11:00 A.M., V2 (Director of Nursing) said that R5 returned to the facility the evening of 8/20/2024.</p> <p>On 8/21/2024 at 11:30 A.M., R5 was observed sitting at the edge of her bed. R5 was calm, soft spoken, was alert and oriented times 3, but with some forgetfulness with dates. Surveyor introduced herself and asked R5 how staff are when providing care to her. R5, with teary eyes had responded around 10 days ago, there was this CNA, muscular built, tall and he was black. I never seen him before, so I assumed he was from staffing agency. He gave me his name. He came with an attitude, and at 5:00 A.M., he took me to bathroom, changed my diaper, wiped me with wipes then pinched my vagina. I slapped his hand and told him not to do that and I was worried that if he did that to me, what else can he do for other residents that cannot say something or fight back. R5 said she reported this to V17 (counselor) a few days after it happened before she went to the hospital on 8/16/2024. R5 said that V17 had advised her not to tell anyone and that V17 will follow it up. R5 said that however, to this day, V17 had not come back to her for an update. R5 also said that she had reported to a hospital staff on 8/16/2024 regarding the sexual abuse by this described CNA. Surveyor asked R5 if V1 and or V2 had already talked to her regarding this sexual allegation. R5 said that no one had interviewed her from the facility of what happened. R5 gave permission to surveyor to inform V1 and V2.</p> <p>Upon prompting, V1 and V19 (Director of Operation for the company organization) went to talked to R5. R5 had stated the same scenario regarding this individual CNA that had allegedly pinched her vagina.</p> <p>Review of the schedule for the last 2 weeks showed V6 (CNA), happened to be the only one male CNA from staffing agency that was assigned to R5 on 8/12/2024 for the night shift.</p> <p>On 8/21/2024 at 12:40 P.M., V6 said he introduced himself by name. V6 said that he took care of R5 on 8/12/2024. V6 also said that he had changed R5's bedding because it was wet. V6 also said that he changed R5's incontinence brief.</p> <p>The facility's policy titled Abuse, dated 11/28/2017 showed, 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 . The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of all allegations.</p> <p>TYPES OF ABUSE .1. Physical abuse .4. Sexual abuse . ABUSE COORDINATOR: The Administrator is the abuse coordinator in this facility and is responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect .A report will be made to the local police department immediately and not exceeding 2 hours after forming the suspicion or allegation of sexual abuse if there is serious bodily injury, and within 24 hours of the allegation being made, if there is no serious bodily injury.</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15845</p> <p>Based on observation, interview, and record review, the facility failed to ensure radiological services were provided timely, and to meet the needs of the residents' with a change in medical condition.</p> <p>This applies to 1 of 3 residents (R1) reviewed for injury of unknown origin.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. R1 was sent to the hospital on 8/16/2024 due to acute comminuted fracture of right proximal tibia and fibula. R1's diagnoses included ESRD (End Stage Renal Disease, dependent on dialysis, anemia, atherosclerotic heart disease, congestive heart failure, chronic pain, dementia, diabetes mellitus.</p> <p>R1's MDS (Minimum Data Set) dated 6/11/2024, shows R1 had severe cognitive impairment, and required extensive assistance with bed mobility, hygiene, and uses mechanical transfer lift device for transfers to recline wheelchair during dialysis days. R1 goes to dialysis 3 times a week. R1 goes to the facility's dialysis unit in his reclining wheelchair and was propelled by the staff.</p> <p>The progress notes showed:</p> <p>-8/13/2024 documented by V3 (Nurse Practitioner) showed that R1 Patient seen today per nursing request. Per NOD (Nurse on Duty), patient was being moved and shouted out when his right leg was being touched and moved .Unable to state due to dementia .Assessment and Plan: Right knee pain .will order an x-ray.</p> <p>-8/15/2024: documented by V3 showed: Patient seen today for a f/u (follow-up) visit for right knee pain. X-rays were ordered last visit, no results . Right knee pain: x-ray ordered but no results .notified NOD (Nurse on Duty) to f/u and re-order.</p> <p>-8/16/2024 at 3:54 P.M. showed that x-ray result was available and was relayed to V3 with an order to send R1 to hospital for further evaluation and treatment. R1 was admitted with fracture and returned to the facility on [DATE] with immobilizer splint to the right leg.</p> <p>The POS (Physician Order Sheet) for the month of 8/2024 showed an order dated 8/13/2024 at 12:45 P.M. given by V3 for an x-ray to right leg for R1.</p> <p>The progress notes dated 8/16/2024 at 3:54 P.M. showed that x-ray result was available and was relayed to V3 with an order to send R1 to hospital for further evaluation and treatment. R1 was admitted with fracture.</p> <p>(continued on next page)</p>

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility documentation shows R1 did not receive the right leg X-ray for more than 48 hours after the order was placed by V3 on 8/13/2024 at 12:45 P.M. The facility's Radiology Results Report showed that x-ray of the right leg was done on 8/16/2024 at 12:00 Midnight. The result showed; result showed 1. Acute appearing complex nondisplaced fracture of the proximal tibial/diaphyseal junction, with approximately 20-degree posterior angulation and approximately 30-degree angulation lateral angulation of the distal fracture moiety. 2. Acute appearing nondisplaced up to 2 cm (centimeters) impacted fracture of the proximal humeral metaphyseal/diaphyseal junction.</p> <p>The progress notes dated 8/16/2024 at 3:54 P.M. showed that x-ray result was available and was relayed to V3 with an order to send R1 to hospital for further evaluation and treatment. R1 was admitted with fracture.</p> <p>The hospital record dated 8/16/2024 showed that R1 was admitted due to traumatic closed displaced fracture of the proximal tibia and fibula. The ED (Emergency Department notes) showed that R1 was presented with chief complaint of right leg pain, was bed bound, was alert and oriented to self only and that R1 said he fell yesterday. The Hospital notes also showed that R1 uses mechanical transfer lift device, and it was unclear how the fractured occurred, if this was caused mechanical related to fall. R1 was seen by orthopedic surgeon and treatment was leg brace wrapped with ace bandage and for follow up visit to orthopedic as outpatient. R1 returned to facility on 8/20/2024.</p> <p>On 8/21/2024 at 12:59 P.M., V11 (CNA/Certified Nurse Assistant) said that she noted that R1 had shouted (pain right leg) when V11 tried to provide care to R1. V11 said it was unusual for R1 shouting of pain, so she immediately reported to V10 (RN/Registered Nurse).</p> <p>On 8/21/2024 at 1:30 P.M., V10 said that she informed V3 on 8/13/2024 at around noon of R1's condition that R1 shouted of right leg pain. V10 said that V3 gave an order for right leg x-ray on 8/16/2024 at around noon. V10 said that V3 asked for x-ray result when visited R1 for follow up of R1's leg pain. V10 said that x-ray was not done.</p> <p>On 8/21/2024 at 1:45 P.M., V2 (Director of Nursing) said that she had no explanation why the x-ray was not done timely.</p> <p>On 8/20/2024 at 2:30 P.M., V3 said that she saw R1 on 8/13/2024 around noon time because of right leg pain. V3 said she immediately ordered x-ray of the right leg to determine the cause of right leg pain and to provide appropriate treatment to R1. V3 also said that a follow up visit was made by her to see R1 on 8/15/2024. V3 said that the x-ray that she ordered on 8/13/2024 was not done. V3 said the expected that x-ray result should have been available within 24 hours when it was originally ordered on 8/13/2024. V3 added that due to delay of x-ray diagnostic examination, there was a delay of treatment and that if the x-ray result was available sooner, R1 would have been sent sooner to the hospital for appropriate treatment of the fractured right leg.</p> <p>On 8/20/2024 at 10:00 A.M., R1 was observed in bed. R1 was agitated when spoken to. V2 (Director of Nursing) assisted to observe R1's lower extremities. R1 was observed with a right leg brace splint that was wrapped with elastic bandage. R1 said I fell few days ago, my knee hurts. During this time, V2 said that R1 was hard to determine if he was really in pain because of cognitive impairment.</p>		