STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145665	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at the Lake,the	2534 Elim Avenue Zion, IL 60099

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure tracheostomy care was provided in a manner to prevent cross-contamination and was completed as ordered for 1 or 3 residents (R1) reviewed for tracheostomy care in the sample of 5. The findings include: On 7/9/24 at 1:36 AM, V6 (Respiratory Therapist - RT) donned a gown, mask and gloves to enter R1's room. R1's door had a Enhanced Barrier Precautions sign affixed to it. R1 was in lying in bed with the head of the bed elevated. R1 had a tracheostomy (trach) attached to humidified oxygen. V6 informed R1 that he was going to provide trach care and R1 removed her speaking valve from the tracheostomy opening. V6 removed R1's inner cannula and placed the old one the bed, next to her right hand. R1's old inner cannula had some secretions noted inside the tube. V6 used the same, soiled gloved hand to open a new inner cannula and place the clean one into R1's trach. V6 continued to use these same gloves to removed R1's trach dressing. The dressing had a moderate amount of yellow, thick secretions noted. V6 folded this dressing in half and placed it on R1's bed, next to the old inner cannula. R1 started coughing and V6 obtained a suction tube, opened it with his soiled gloves and proceeded to suction down R1's tracheostomy. After completing this, V6 removed the soiled gloves and placed them on the bed with R1's soiled dressing, old inner cannula, and wrapper from the suction tubing. V6 opened the trach care kit; removed the gloves, container for suctioning, and a drape; and placed them directly on R1's linens, near the soiled supplies. V6 did not use the drape during the procedure. V6 donned the gloves, cleansed around R1's trach stoma with the provided materials and applied a clean dressing. V6 said trach care is a clean procedure and gloves should be changed whenever they are dirty. V6 said all the trach treatments are documented in the Respiratory Record. V6 said the treatments should be signed out as completed. V6 said if the trach care isn't signed out, then there is no way to know that it was completed. R1's Facesheet dated 7/9/24 showed diagnoses to include, but not limited to: chronic respiratory failure, lack of coordination, abnormal posture, seasonal allergic rhinitis, diabetes, pulmonary hypertension, morbid obesity, chronic kidney disease, obstructive sleep apnea, chronic pain syndrome, chronic obstructive respiratory disease, lymphedema, and congestive heart failure. R1's facility assessment dated [DATE] showed she was cognitively intact and had a tracheostomy. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's July 2024 Respiratory Record orders to: Change the inner cannula every shift and PRN (As needed) to prevent mucous plugs; chlorahexadine (antiseptic oral rinse) - give 15 milliliters (ml) two times a day; Cleanse trach stoma with trach kit every shift to prevent infection secondary to secretions; and suction every 4 hours. These treatments were not completed as ordered on 7/3/24-7/7/24. On 7/10/24 at 12:20 PM, V11 (RT) said trach care isn't a sterile procedure, but it's important to try to be sterile with suctioning because you are going into the resident's airway. V11 said there should be a designated dirty area, like a garbage can, bag, or container, to dispose of the soiled supplies. V11 said soiled supplies should not be placed directly on a resident's bed and certainly shouldn't be near clean trach care materials. There's a risk of cross-contamination and that increases the resident's risk for developing an infection. V11 said the kits are big enough that one side could be used as clean and the other could be used as dirty. V11 said clean trach supplies should never be placed directly on a residents bed because we don't know what is on that bed and we don't want to introduce microorganisms into their airway. V11 said the drape, from the kit, can be used or a towel. V11 said it's best to go from sterile suctioning to the dirtier tasks, like cleaning the stoma and changing the inner cannula. The surveyor described the trach care observation and V11 replied, It shouldn't have happened like that. We should always move from clean to dirty to reduce the risk of infection. V11 said routine trach care included, but was not limited to: changing the inner cannula, suctioning, oral care, cleaning around the stoma, and applying a new dressing. V11 said the RT should document this care in the Respiratory Record to show it was done. V11 said trach care is important for the maintenance of the trach and to reduce the risk of infection. The facility's Tracheostomy Care Guidelines revised 6/6/24 showed, It is the policy of this facility to maintain patency of the tracheostomy tube and reduce the risk of infection for a resident on tracheostomy management. Procedures: 1. Review physician orders and facility protocol . 3. Provide tracheostomy care at least every shift and PRN. 4. Aseptic (sterile) technique observed for recent tracheostomy (first 5 days). 5. After stoma is healed, clean technique is used for dressing and tie changes. 6. Use sterile technique during suctioning of the tracheostomy tube . 13. Suction tracheostomy (follow suctioning policy) 14. Remove soiled tracheostomy dressing before removing gloves. Discard in red bags. 15. Wash hands and put on sterile gloves. 16. Open sterile tracheostomy kit . 28. Discard supplies per protocol in red bag . 30. Documentation: a. date/time procedure performed. b. Amount, color, and characteristics of secretions. c. Condition of stoma. d. Patient response to procedure. e. Cardiopulmonary status of resident. f. Notify MD for patient refusal.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39537 Based on observation, interview, and record review the facility failed to maintain the third floor shower room in a safe, comfortable, and sanitary condition and failed to maintain a resident's air conditioning unit in a safe manner (R1). This applies 53 residents that use the third floor shower room. The findings include: 1. The facility listed 53 residents that use the third floor shower room on the facility's 7/8/24 Census for the third floor. On 7/9/24 at 11:24 AM, V4 (Maintenance Director) arrived at the third floor shower room. V4 said this shower room is used for all the residents on the third floor that take showers. V4 said the shower room was still in use and had not been shut down. The shower room had a keypad to lock the door. V4 was not aware of the code and had to seek out staff assistance to get the shower room open. The shower room was still still damp and humid. The first shower stall to the left of the door, had a grates in the ceiling above the shower area. There were steady drops of water falling from the grates. The surveyor asked V4 where the water was coming from. V4 replied, I'm not sure, maybe the drain from the forth floor shower. I will take a look at it. The shower room hallway, that lead to the separate rooms had an area in the ceiling, above the wired fire alarm unit, that was wet and had a small square drywall patch. The drywall patch was wet with brown and gray staining. The surveyor asked V4 what happened here. V4 replied, A few days ago, one of the CNAs (certified nursing assistants) left the showers running upstairs and there was a water leak. There was bubbling on the ceiling near this patched area. The surveyor asked why there were no drying fans. V4 replied, Well I had to make sure it was done leaking. The surveyor asked if it was dangerous for water to leak onto electrical sources and V4 replied, It could be, yes. The right, rear shower room had a large window, covered with a privacy curtain. The inner, upper surface of the widow well had two large, round, black stains. The surveyor asked V4 what that was. V4 replied, It's from the air conditioning unit in the room above leaking. The surveyor asked V4 if that looked like mold and V4 replied, Yes, it does. I'll shut down this shower room right now and we will have to clean the area. V4 said the maintenance staff wears masks when they clean mold because it can be bad for their breathing. The surveyor asked V4 if the residents should be using an area with mold and he replied, No. V4 said he was unsure how long this area had been there. In the same shower room, above the shower stall, in the left corner. There was an large area in the corner of wet, bubbling paint and peeling drywall. In the corner or this area and under the peeled drywall there was patches of black and gray. V4 said this areas was from the shower leak that happened a few days ago (The Maintenance log showed the issue was reported 7/1/24 - 8 days prior to these observations). The surveyor asked why these areas had not been dried, treated, and repaired in the last week. V4 did not provide an answer, but stated, We will work on it now. V4 said he doesn't complete paperwork for the maintenance requests. V4 stated, I think the Receptionist does all that. V4 was unable to provide any documentation of steps taken by the facility in the last 8 days to mitigate the multiple water leaks. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24 at 9:29 AM, V4 (Maintenance Director) said the shower room was being cleaned and fixed now. Upon entering the shower room, there was a strong odor of bleach. The first shower room on the left continued to have water leaking from the grate, above the shower. The surveyor asked V4 why this area was still leaking. V4 said the leak was coming from the shower drain. V4 said the facility had not contacted any contractors to assist with the multiple water leaks. V4 said the maintenance department will try to fix it first, but can call a contractor if needed. V4 said the maintenance department did not inspect the shower rooms on a regular basis. The surveyor asked why the facility didn't attempt to make repairs in the last 9 days. V4 shrugged his shoulders and lifted his hands, palms up (in a I don't know gesture). The facility's Maintenance Log showed on 7/1/24 the 4th floor showers were leaking into the 3rd floor showers. The facility's Maintenance Policy dated 6/6/24 showed, It is the facility's policy to maintain equipment and the building environment. Procedures: 1. All resident care equipment and the building environment will be maintained by the maintenance department. 2. Any staff who is made aware of a malfunctioning equipment or any part of the building that is in disrepair will report the issue to the maintenance department. 3. The maintenance department will address the issue as soon as possible . A Mold and/or Water Mitigation Policy was requested, but was not received. 2. On 7/9/24 at 12:35 PM, R1 was lying in bed with humidified oxygen to her tracheostomy collar. R1 said she does have episodes where she gets short of breath. R1 stated, Tell me how that makes sense, and pointed to a whole in the window sill. A small, metal grate was missing from R1's air conditioning unit. The air conditioner controls were approximately 2 feet deep inside the hole. There was pink insulation, the wall frame, pipes, and dressing packages visible inside the wall. R1 stated, I have lung problems, I can't imagine it's good for me to be breathing whatever is in their. I can see the pink insulation from here. I tell them and nothing gets done. It's been like that for months. At 1:36 PM, V6 (Respiratory Therapist) provided tracheostomy care to R1. R1's box of tracheostomy supplies were lying next to the hole in the widow sill. The surveyor asked V6 if there should be a hole there and he replied, No, but it's been like that for a long time. I can see the inside of the wall there. On 7/10/24 at 9:47 AM, V4 (Maintenance Director) said R1's window sill was missing an air conditioning cover. V4 said it shouldn't be just a hole like that. V4 said the maintenance department doesn't inspect the units regularly, but relies on staff to report concerns like this. V4 said there should always be a cover over this opening.