STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145809	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Northbrook,the	263 Skokie Boulevard Northbrook, IL 60062

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review, the facility failed to implement its abuse prevention policy by failure to complete abuse assessment and update abuse care plan after allegation of resident-to-resident physical altercation. This deficiency affects three (R25, R78 and R87) of three residents reviewed for Abuse prevention policy. Findings include: 1. Review Incident report of Resident-to-resident physical altercation involving R25 and R87 completed by V1, Administrator, indicated on 3/22/24 at 7:05AM, upon entering room, V28, RN (Registered Nurse), observed R25 on the floor. Upon initial interview of residents, it appeared that there was a disagreement over the volume of R87's TV. As R25 attempted to scurry away back to his bed with R87's remote, he lost his balance and fell . V1 interviewed R25 on 3/25/24. R25 admits to trying to take R87's remote control on the morning of 3/22/24, as he felt the volume of his TV was too loud. R25 also admitted to then taking his cell phone off the bed after R87 grabbed the remote back. R25 alleged R87 pushed him when R87 attempted to get his cell phone back from him, causing him to lose his balance and fall. R25 was immediately assessed and was able to move all his extremities with only slight discomfort to his back. R25 was sent to local hospital for precautionary evaluation and returned soon thereafter with no new orders or injury. V1 interviewed R87 on 3/22/24 and 3/25/24. In both instances, R87 alleged on 3/22/24, his roommate R25 walked over to his bed unprovoked and grabbed the remote control off his bed. R87 was able to immediately retrieve his remote at which time R25 grabbed for his cell phone. As R87 attempted to grab his phone back, R25 lost his balance and fell as he tried to scurry away R87. R87 strongly denied ever pushing R25 at any time. There were no witnesses to the alleged incident. R25 was readmitted on [DATE], with diagnoses listed in part but not limited to Psychotic disorder with delusion due to known physiological condition, bipolar disorder current episode depressed severe with psychotic features, Dementia with behavioral disturbance, Schizophreniform disorder, Alzheimer's disease, Cerebral infraction. Abuse/Neglect assessment done on 12/8/16 indicated he is at risk for abuse due to his history of abuse and substance abuse, as well as his mental health diagnosis and his history of abrasive/aggressive behavior. Abuse/neglect /trauma factors care plan for abuse neglect trauma assessment updated on 10/21/22. Both Abuse/neglect assessment and Abuse care plan intervention were not updated after the physical abuse resident to resident altercation on 3/22/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R87 was admitted on [DATE], with diagnoses listed in part but not limited to Dementia with other behavioral disturbance, Paranoid personality disorder, Psychosis, Alzheimer's disease with late onset. Abuse/Neglect assessment done 2/10/22 indicated he at risk due to mental issues, presents with signs and symptoms of mood distress. Resident has history of exhibiting verbal outbursts when he becomes upset. Comprehensive care plan did not indicate abuse/neglect prevention care plan. After resident-to-resident physical altercation incident on 3/26/24, both abuse/neglect assessment and abuse care plan were not updated. On 6/4/24 at 8:24AM, R87 was lying in bed. He was alert and oriented, and could verbalize his needs to staff. R87 said he denied having resident to resident alteration with another resident, and denied incident happened last March 2024. On 6/4/24 at 8:38AM, R25 was lying in bed sleeping. Several attempts were made to interview R25, but he was sleeping, and nursing staff said that he becomes agitated when they wake him. On 6/4/24 at 8:53AM, V4, Social Service Director (SSD), said they do abuse/neglect assessment upon admission, quarterly, and as needed, such as when there is an allegation or incident of abuse. V4 said abuse/neglect prevention care plan is formulated after assessment, if indicated. V4 said after abuse/neglect/resident to resident altercation allegation or incident, the abuse/neglect assessment and abuse prevention care plan is updated. Reviewed R25's and R87's resident to resident physical altercation incident report with V4. Reviewed R25's and R87's abuse assessment and abuse prevention care plan with V4. Medical records of both residents indicated abuse/neglect assessment and abuse care plan was not updated after the resident-to-resident physical altercation incident on 3/22/24. 2. R78 was admitted on [DATE], with diagnoses listed in part but not limited to Epilepsy, Mild cognitive impairment, Dysarthria following cerebral infarction, Apraxia following cerebrovascular disease. Abuse/neglect admission assessment done on 10/3/19 indicated she is at risk for abuse. Resident triggered on numerous areas on depression assessment and per guardian, has hoarding tendencies. Guardian reports compulsive spending. Care plan indicated presence of abuse and neglect factors. She has history of serous trauma. Abuse assessment and abuse/neglect prevention care plan were not updated after resident-to-resident physical altercation incident on 6/7/23. R78's resident to resident physical altercation, dated 6/7/23 at 8:40AM, indicated R78 stated another resident hit her on her right shoulder as they passed each other in the hallway earlier in the morning. Both residents were immediately separated and monitored for safely. Upon initial assessment, R78 was noted with no redness, bruising or discomfort. Later in the day of 6/7/23, R78 complained of slight discomfort to her right shoulder. Tylenol was given with good result. Precautionary X-ray taken with negative results. R78 did not complaint of additional lingering discomfort. There were no witnesses to the incident or what led to the incident. On 6/7/24 at 9:30AM, reviewed R78's resident to resident physical altercation, dated 6/7/23, with V4, SSD. R78's abuse/neglect assessment and abuse prevention care plan were not updated after the incident of resident-to-resident altercation. V4 said resident 's abuse assessment and abuse prevention care plan should be updated after resident-to-resident altercation. Facility's policy on Abuse and Neglect, reviewed 7/14/23, indicates: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Policy statement: it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Prevention: *Identify, correct, and intervene in situations in which abuse, neglect, exploitation and or misappropriation of resident properly is more likely to occur. *Develop and implement policy on abuse, neglect, theft, exploitation, and misappropriation of property. *Identification, assessment, care planning for intervention and monitoring of resident with needs and behavior that might lead to conflicts or neglect. *The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who toileting assistance to assistance to urinate or defecate in their beds.

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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** 39781 Based on observation, interview, and record review, the facility failed to ensure the resident received medications, treatments, and care as ordered by physician. This deficiency affects one (R25) of three residents in the sample of 24 reviewed for Quality of care. Findings include: R25 was readmitted on [DATE] with admitting diagnoses but not limited to Type 2 Diabetes Mellitus (DM), Hypertension, Chronic Kidney disease, Cerebral infarction, Psychotic disorder with delusions due to known physiological condition, bipolar disorder current episode depressed severe with psychotic features, Dementia with other behavioral disturbance, Anxiety disorder, Alzheimer's disease, Gastroesophageal reflux (GERD). R25's physician order sheet indicates: Consistent carbohydrates diet. Regular texture. Thin liquids. Double portions. Metformin HCl oral tablet 500mg 1 tab twice a day for DM, Lamotrigine oral tablet 25mg 2 tabs for bipolar, Lorazepam tab 0.5mg 1 tab by mouth daily for anxiety, Risperdal 3mg 1 tab by mouth twice a day for schizophrenia, Sertraline HCl 100mg 1 tab by mouth daily for depression, Torsemide 20mg 1 tab by mouth daily for edema, Aldactone 25mg 1 tab by mouth daily for edema, Aspirin EC delayed release 81mg 1 tab by mouth daily for anti-platelet aggregation, Cholecalciferol 1000 unit 1 tab by mouth daily for Vit D deficiency, Claritin 10mg 1 tab by mouth daily for allergy, Folic acid 1mg 1 tab by mouth daily for supplement, Lidocaine external patch 4% apply to low back, bilateral knees in the morning for pain, Miralax oral powder 17 gm/scoop 1 scoop by mouth twice a day for constipation, Pantoprazole sodium oral tablet delayed release 20mg 1 tab by mouth daily before breakfast for GERD, Senna plus 8.6-50mg 1 tab by mouth twice a day for constipation, Thiamine HCl 50mg 1 tab by mouth daily for supplement, Vit B12 100mg 1 tab by mouth daily for supplement. On 6/4/24 at 8:38AM, R25 was lying in bed sleeping, with mouth open and eyes covered with wash cloth. Breakfast tray was left on bedside tray table. On 6/4/24 at 9:36AM, R25 was still sleeping in bed, with breakfast tray left on bedside tray table. V13, Licensed Practical Nurse (LPN), said R25 has behavioral issues. R25 does not want to be awakened. R25 can be agitated, aggressive, and will call 911. They will just wait for him to wake up. On 6/4/24 at 11:38 AM, R25 was still sleeping in bed. V21, Certified Nurse Assistant (CNA) Supervisor, said they took away the breakfast tray because R25 was still sleeping. V21 said R25 does not want to be awakened. R25 can be agitated, aggressive, and will call 911. They will just wait for him to wake up. On 6/4/24 at 12:16PM, R25 was still sleeping in bed, with lunch tray left on bedside table. On 6/4/24 at 12:57PM, R25 was still sleeping in bed, with lunch tray left on bedside table. On 6/4/24 at 1:42PM, R25 was still sleeping in bed, with lunch tray left on bedside table. V27, CNA, said she is the CNA assigned for R25. V27 said they don't wake up R25 for breakfast or lunch; they will just leave the tray at bedside for him to eat when he wakes up. (continued on next page)

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	145809	A. Building B. Wing	06/07/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 2:30PM, R25 was still sleeping in bed, with lunch tray left on bedside table. V3, Assistant Director of Nursing (ADON), and V13, LPN, both said R25 has behavioral issues and can be agitated and aggressive when awakened for meals. R25 will wake up on his own time. Both said R25 has routine sleeping pattern of awake at nighttime and sleeping during daytime. V13 said she did not give R25's morning medications because he is sleeping. V13 said he has daily and twice a day scheduled medications. V13 said she did not call the doctor of R25's omission of 9am scheduled medications, and omission of breakfast and lunch meals because this is his baseline behavior. Reviewed R25's medical records with V13 and V3. R25 is diabetic and on metformin 500mg twice a day. Blood sugar test last done 6/1/24. V13 said R25 has order of blood sugar test before meal daily. The facility did not formulate individualized care plan interventions to address resident needs such as adjusting time of his medications, treatment, and care. There are discrepancies with documentation in MAR (Medication Administration Record) and Restorative program log for May and June 2024, indicating medications and treatment were given despite resident was sleeping. Nurse Practitioner's documentation on 5/29/24 had no documentation of R25's omitting medications, treatment, and care due to alteration in sleeping pattern. Dietary/Nutrition documentation on 5/20/24 had no indication of R25 missing breakfast and lunch due to sleeping. Daily blood sugar testing before breakfast reviewed from May 1 to June 4, 2024, indicates missing blood sugar test on the following days: June 2, 3 and 4. May 17, 19, 20, 21, 22, 23 and 24. Restorative log documentation on 6/4/24 indicated Dressing and grooming and transfers were provided for 15 mins, but R25 was observed sleeping. Restorative program for Active range of motion and ambulation daily as ordered was not done. R25's Medication administration Record (MAR) from May 1 to June 4 ,2024 indicates medications at 9am were given (marked checked), even R25 is sleeping. On 6/6/24 at 10:00AM, informed V2, Director of Nursing/DON of concerns identified that R25 has not been getting his scheduled 9am medications, treatment and care as ordered by physician. All interdisciplinary team is aware of R25 sleeping habit (awake at night and sleeps during the day) but no attempts to individualized care plan intervention to meet resident needs such as changing medications and treatment timing. The physician, Nurse Practitioner, dietitian, and pharmacist were not notified of resident not receiving is scheduled medications, treatment, and care at 9am because he was sleeping. There are no documentation in R25 progress notes that physician or nurse practitioner were notified of resident omission of medications, treatment, and care. No nursing monitoring documentation of resident's activities at night when he is awake. On 6/6/24 at 11:03AM, V22, Physician, said he is aware of R25 alteration in sleeping pattern, but he is not aware of each individual occurrence that R25 omitted his medications because he was sleeping. V22 said he is expecting the nurses to call him if the resident did not take his medications or treatment was not given so that he can make necessary changes in timing of medications or treatment. On 6/7/24 at 11:32AM, V32, Nurse Practitioner, said she comes weekly to the facility, but she is not aware the resident has been missing/omitting his medications and treatments because he is sleeping. She was only notified recently and addressed the concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy on Missed Medication revised 7/28/23 indicates: Policy statement: It is the facility's policy to administer medications to the residents and promote resident's rights of refusal at the same time. The policy will address missed medications. Procedures: 3. If the resident refuses the medication, explain to the resident the importance of the medication and the risk associated with missing the dose 4. If the resident continues to refuse the medication, indicate in the eMAR the refused medication 6. If the medication that is missed is ordered more than once daily, call physician to determine if the physician would like to order anything related to the missed dose or would want to have missed dose administered to the resident when is become available. Facility's policy on Physician orders revised 7/28/23 indicates: Policy statement: It is the policy of this facility to ensure that all resident/patient medications, treatment, and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as it is written in the POS (Physician order sheet). Procedures: 2. All medications administered to the resident/patient must be ordered in writing by the patient's attending physician. 6. Physician orders will be carried out at a reasonable time. 9. Provision of care, treatment and services administered by the facility to the patient must be approved by the attending physician unless these treatment and services are governed by the facility's clinical policy and procedures and approved by the medical director. .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review, the facility failed to follow up with pharmacy recommendation review and document physician response in resident medical record. This deficiency affects one (R28) of three residents in the sample of 24 review for Pharmacy medication review. Findings include: R28 was admitted on [DATE], with diagnoses listed in part but not limited to Schizoaffective disorder, Bipolar disorder, Antisocial personality, Anxiety disorder, Pressure ulcer, Spina bifida. Active physician order sheet (POS) indicates Depakote ER oral tablet extended release 24-hour 500mg give 1 tablet by mouth two times a day for treatment. Valporic Acid oral capsule 250mg give 1 capsule by mouth two times a day for treatment. No clinical indication for usage of Depakote and Valporic acid. On 6/4/24 at 11:08AM, R28 was lying in bed. He was alert and oriented, could verbalize self to staff. V15, Wound Care Nurse, said R28 has behavioral issues. R28's Consultant pharmacist recommendation, dated 5/30/24, indicated: Resident has orders for Depakote ER 500mg BID (twice a day) and Valporic acid 250mg BID which may represent duplicate therapy as both have very similar therapeutic activities. Please clarify with prescriber if resident is to continue both of the above orders. On 6/6/24 at 1:32PM, V3, Assistant Director of Nursing (ADON), said they follow up with pharmacy recommendation review within 3 days. Informed V2, Director of Nursing (DON), V3, ADON, and V29, Nursing Consultant, of R28's Pharmacy recommendation, dated 5/30/24, was not followed up. R28's medical records including active physician orders and progress notes does not indicate documentation for clarification of physician orders for Depakote and Valporic acid as recommended by pharmacist. On 6//6/24 at 2:18PM, V26, Psychotropic Nurse, presented a copy of the pharmacy recommendation where she just wrote she notified the physician and continue as ordered. She said she did not write a physician order on R28's physician order sheet, or document notification with orders in progress notes. V26 said V3, ADON, received all the pharmacy recommendations for follow up. On 6/7/24 at 9:15AM, V3, ADON, said after the Pharmacist consultant completed the resident's medication review, the recommendations were emailed to V2, DON, and V3, ADON. V3 is responsible for following up with pharmacy recommendation within 3 days. V3 said V26, Psychotropic nurse, is responsible for following up with psychotropic medication recommendations. V3 said after the nurse call the physician or Nurse Practitioner regarding pharmacist recommendation, they should document it in the resident progress notes and write orders in there is new orders made. On 6/7/24 at 10:02AM, V26, Psychotropic nurse, was notified Depakote and Valporic acid written on POS did not have clinical indication for medication usage. Facility's policy on Medication regimen review, revised 7/28/23, indicates: (continued on next page)

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	145809	A. Building B. Wing	06/07/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: The consultant pharmacist shall provide pharmaceutical care consultation including the medication regimen review at least once a month for each resident residing in certified areas of a skilled long term care facility. For residents residing in long term care facilities licensed for the developmentally disabled or assisted living, pharmaceutical care consultation including medication regimen review will be conducted in compliance with state regulation. Procedure: 6. The consultant pharmacist us available to consult with the prescribing physicians, the Medical Director or nursing staff regarding recommendations resulting from the medication regimen review. It is the responsibility of the facility to assure that each of the recommendations result in a written response by either a physician or nurse, as appropriate. The attending physician/Medical Director must document in the medical record that the identified irregularity has been reviewed and subsequent action taken, if required. In the event where no change will be made as a result of the identified irregularity, the physician/Medical Director will document rationale in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39781 Based on observation, interview, and record review, the facility failed to keep the medication cart locked during medication administration when cart was out of site. The facility also failed to keep the medications refrigerated as manufacturer recommendation. This deficiency affects all three residents (R49, R55 and R97) in the sample of 24 reviewed for Medication Safety Storage. Findings include: On 6/4/24 at 6:15AM, checked medication cart and count controlled substance/narcotic medications with V10 RN (Registered Nurse). Observed R49 's opened Lorazepam 2mg/ml bottle in the locked controlled drawer in the medication cart. V10, RN, said they kept all the controlled substance/narcotic meds in the locked drawer in the medication cart. Informed V10 lorazepam should be in the medication refrigerator as indicated on the medication bottle and manufacturer recommendation. On 6/4/24 at 6:33AM, checked medication cart and count controlled substance/narcotic medications with V11 RN. Observed R97's Lorazepam 2mg/ml bottle in the locked controlled drawer in the medication cart. V11 RN said they keep all the controlled substance/narcotic meds in the locked drawer in the medication cart. On 6/4/24 at 7:45AM, observed V13, RN, prepared medications for R55. After she prepared medications, the medication cart was left unlocked, and V13 went to R55's room to administer medications. V13 went back to unlocked medication cart at 7:57AM. V13 said she just forgot to lock it. She added it should be locked at all times when the medication cart is out of site during medication administration. On 6/4/24 at 11:38AM, V2, Director of Nursing, said the medication cart should be always locked when out of site during medication administration. V2 said they should follow manufacturer recommendation for medication storage. Facility's policy on Medication Storage, Labeling and Disposal revised 8/24/23. Policy statement: It is the facility's policy to comply with federal regulations in storage, labeling and disposal of medications. 3. Medications will be stored safely under appropriate environment controls. 4. Medications will be secured in locked storage area. Facility's policy on Medication Pass revised 7/28/23 indicates: Policy statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures: Controlled substances: 2. All meds are to be stored I room at temperature as recommended by manufacturer (example: meds needing refrigeration will be stored in the refrigerator)