

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145860	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/12/2024
NAME OF PROVIDER OR SUPPLIER Grove of Skokie, The		STREET ADDRESS, CITY, STATE, ZIP CODE 9000 LA Vergne Avenue Skokie, IL 60077	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview and record review the facility failed to ensure soiled linens were handled in a manner to prevent cross contamination, and failed to ensure incontinence care was completed in a manner to prevent contamination for 1 of 3 residents (R1) reviewed for infection control in the sample of 3.</p> <p>The findings include:</p> <p>R1's admission sheet shows he was admitted to the facility on [DATE] with multiple diagnoses. His 7/24/24 facility assessment and care screening documents him to be cognitively intact. The same document shows R1 has a colostomy and to always be incontinent of urine. The functional assessment shows R1 requires substantial to maximal assistance to roll side to side, sit up, and to transfer between surfaces.</p> <p>On 10/12/24 at 9:30 AM, R1 was observed lying in bed wearing a hospital gown, and an incontinence brief. V4 CNA (Certified Nursing Assistant) entered the room and removed the top sheet. V4 removed R1's incontinence brief, and V5 CNA assisted her with positioning. R1's scrotum and groin area were bright red after the removal of the soiled brief. V4 and V5 rolled R1 over to his right side. The pad and sheet under him were visibly soiled from the buttocks area and up his back. After the brief was removed, V4, using a disposable wipe, did not open the wipe, and blotted parts of R1's buttocks. She did not wash his buttocks or his backside. V4 then wiped the buttocks with ointment. V4 and V5 rolled R1 over to his left side to remove the soiled linens. Once the linens were removed from under R1, V5 threw them on the floor. Without cleaning up the groin and scrotum from urine, V4 placed ointment across the area and placed the clean incontinence brief.</p> <p>On 10/12/24 at 1:00 PM, V2 DON (Director of Nursing) said R1 should be changed every 2 hours. When he is changed, the CNA should be using soap and water and cleaning wherever the skin has been soiled. The areas should include the groin and scrotum. V2 said if the urine is not cleaned off it could cause skin breakdown. The disposable wipes should have soap on them, and opened up to use. V2 said the soiled linens are to be placed in a bag and should not be thrown on the floor, that is an infection control issue.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145860	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/12/2024
NAME OF PROVIDER OR SUPPLIER Grove of Skokie, The		STREET ADDRESS, CITY, STATE, ZIP CODE 9000 LA Vergne Avenue Skokie, IL 60077	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's 7/31/24 policy for Incontinent and Perineal Care documents it is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident to prevent infection and skin irritation, and to observe the resident's skin condition. Procedures: 6. Wash the perineal area and gently dry after the procedure. 7. Discard disposable items into designated container/plastic bag.</p>		