STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145860	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Skokie, The	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)
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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide needed care and services in accordance with resident's plan of care as ordered by physician, facility's protocol, and professional standard of practice. This deficiency affects two (R2 and R4) of three residents reviewed for Quality of care. Findings include:R2On 9/2/25 at 10:21AM, Observed R2 up in wheelchair. She is alert with cognitive and communication impairment due to intellectual disability. She needs assistance with ADLs (Activity of daily living) and transfers. Assessed skin condition of R2's bilateral under the breast with V8 LPN (Licensed Practical Nurse) and V9 CNA (Certified Nurse Assistant). Observed redness under both breasts. V9 CNA said that she applied this morning Vitamin D ointment. V8 LPN said that R2 has fungal rash, and she has an order of Nystatin powder twice daily, but she has not applied it yet. On 9/3/25 at 10:41AM, Reviewed R2's medical records with V4 Wound Care Nurse. V4 said that R2 ‘s Braden scale upon admission on [DATE] indicated score of 19 at high risk for skin impairment. She developed fungal rash under the breast as reported by nursing staff due to complaint of family member. She said that she observed the skin impairment under R2's bilateral breast but did not do the assessment but initiated the treatment order on 8/25/25. She also said she did not update care plan. She said that their protocol requires written assessment of skin impairment to be documented in wound assessment or progress notes, notify the physician for appropriate treatment order and update the care plan. She said that she just updated the care plan yesterday 9/2/25 when surveyor asked for it. She is not aware that group home case manager came in for complaint on 8/20/25 based on grievance report completed by V2 DON. V4 said that she did not update R2's family member of the treatment obtained for the redness under the breast. V4 said that Vitamin D ointment is not an appropriate treatment for fungal rash under the breast. R2 is admitted on [DATE] with diagnosis listed in part but not limited to Displaced fracture of olecranon process with intraarticular extension of right ulna, Cognitive communication deficit, Genetic related intellectual disability, Disorder of psychological development, Need for assistance with personal care, Difficulty walking, unsteadiness of feet. Physician order sheet indicated Nystatin external powder 100,000 unit/gm apply under both breasts topically every day and evening shift for fungal rash. Cleanse under the breast area with soap and water then apply powder under breast on affected areas ordered 8/25/25. No care plan formulated for under the breast fungal rash until 9/2/25. No documentation of under the breast fungal rash skin assessment and identification in R2's medical record. R2's admission Braden skin assessment indicated at high risk for skin impairment. R2's grievance form completed by V2 DON dated 8/20/25 indicated that R2's home care case manager presented concern about R2's redness under the breast. No documentation of assessment done. Treatment order not obtained until 8/25/25. R4On 9/2/25 at 11:02AM, Observed R4 lying in bed with low air loss mattress. He is alert and responsive to simple questions. He needs maximum to total care assistance with ADLs and transfers. V8 LPN said that R4 has sacral and right hip wound dressing. On 9/2/25 at 11:15Am, V2 DON (Director of Nursing) said that V4, Wound care nurse, is not yet in the building but will come later. She said that the floor nurse does the wound treatment in absence of wound care nurse. Informed V2 that surveyor will observe V8 LPN for R4's wound care. On 9/2/25 at 11:24AM, V8 LPN and V6 LPN reviewed R4's treatment orders and prepared for wound treatment. R4 has left AKA (Above the knee amputation). R4 repositioned to his right side. Observed no sacral wound dressing. R4 has moderate amount of soft brown bowel movement in his adult disposable brief. Observed redness with 100% epithelization tissue. V8 cleansed with NSS. Applied Nystatin powder 100,000 unit/gram to the sacral, applied gauze and covered with bordered gauze dressing. V8 also applied nystatin powder to perineal area. Then R4 repositioned to his left side. V8 removed the wound dressing saturated with moderate serosanguinous drainage. V8 cleansed with NSS. R4 has red wound tissue 50% granulation with 50% yellowish slough attached to the wound base. V8 applied calcium alginate and medical grade honey, gauze and covered with bordered gauze dressing. On 9/3/25 at 10:41AM, Reviewed R4's medical records with V4 Wound Care Nurse. V4 said that R4's re-admission Braden scale assessment dated [DATE] indicated high risk for skin impairment. He has DTI on sacrum and unstageable pressure ulcer on right hip. He has daily dressing and PRN to both sacral and right hip. She said that it's their protocol to follow physician orders in providing wound treatment. The floor nurses are knowledgeable to perform wound care as indicated in treatment record /Physician order. Informed above observation made during wound care with V8 LPN and V6 LPN. R4 is re-admitted on [DATE] with diagnosis listed in part but