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	05/08/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a PASARR (pre-admission screening and resident review) for residents in the facility for a mental disorder or related condition prior to being admitted and failed to ensure residents identified with a mental disorder or related condition were evaluated and provided care in the most appropriate setting for 4 (R2, R4, R7, and R25) of 6 residents reviewed for PASARR screening. Findings include: R2 is [AGE] years of age. R2's medical diagnoses include but are not limited to Dementia diagnosed 6/14/24, Schizoaffective disorder upon admission, Major Depressive Disorder upon admission, and Anxiety upon admission. R2's comprehensive assessment dated [DATE] section C cognitive patterns documents a brief interview for mental status with a score of 11 out of 15. A score of 8-12 indicates R2 has moderate cognitive impairment. On 05/07/25 at 1:14 PM, V10 Admissions Director was inquired of R2's PASARR screening. V10 said, I just started a year ago. I know the PASARR screening was started in 2022 or 2023. I didn't know R2 was supposed to be screened. V10 did not provide a PASARR screening for R2. V10 provided R2's OBRA (Federal Omnibus Budget Reconciliation Act) pre-admission screening from June 1996. On 05/07/25 at 01:21 PM, review of R2's census indicates he was admitted to the facility on [DATE]. Upon review of R2's medical record, there was no documentation of a PASARR (preadmission screening resident review) upon admission. R2's current physician orders document the following medications- Ativan Oral Tablet 1 MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth two times a day. (Antianxiety medication) and Risperidone Oral Tablet 4 MG Give 1 tablet by mouth two times a day for schizophrenia, bipolar. (Antipsychotic medication). R4 is [AGE] years of age. R4 was admitted to the facility on [DATE]. R4's medical diagnoses include but are not limited to Dementia and Schizophrenia diagnosed on admission. Review of R4's electronic medical records does not document a PASARR screening upon admission. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's comprehensive assessment dated [DATE] section C cognitive patterns documents a brief interview for mental status with a score of 3 out of 15. A score of 0-7 indicates R4 has severe cognitive impairment. On 05/07/25 at 11:56 AM, V10 provided R4's preadmission screening and resident review submitted on 5/7/25 at 10:51 AM. V10 Admissions Director was inquired of the newly submitted information. V10 said, R4 never had one so I ran it today. V10 submitted a level 1 screening to the state appointed agency on 5/7/25 when inquired of R4's screening. R4's current physician orders document the following - Behavior Monitoring for Schizophrenia: Monitor for the following: Delusion, Hallucinations, Disorganized speech, Grossly disorganized or catatonic behavior and Negative Symptoms (e.g. reduced emotional expression). There are no current medications related to her diagnoses. R7 is [AGE] years of age. R7 was admitted to the facility on [DATE]. R7's medical diagnoses include but are not limited to Epilepsy, Major Depressive Disorder, and Schizophrenia diagnosed on admission. Dementia was diagnosed on [DATE]. Review of R7's electronic medical records does not document a PASARR screening upon admission. R7's comprehensive assessment dated [DATE] section C cognitive patterns documents a brief interview for mental status with a score of 13 out of 15. A score of 13-15 indicates R7 is cognitively intact. On 05/07/25 at 11:00 AM, V10 provided R7's preadmission screening and resident review submitted on 5/7/25 at 10:42 AM. V10 Admissions Director was inquired of the newly submitted information. V10 said, R7 never had one so I ran it today too. V10 submitted a level 1 screening to the state appointed agency on 5/7/25 when inquired of R7's PASARR screening upon admission. R7's current physician orders document the following medications- Haloperidol Tablet 2 MG Give 1 tablet by mouth two times a day for Anxiety Disorder (Antipsychotic medication), Zoloft Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression (Antidepressant medication), and Ativan Oral Tablet 1 MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth three times a day for Anxiety. R25 is [AGE] years of age. R25's medical diagnoses include but are not limited to Dementia diagnosed 10/1/22, Schizoaffective Disorder, Major Depressive Disorder, and Visual Hallucinations diagnosed upon admission. R25's comprehensive assessment dated [DATE] section C cognitive patterns documents a brief interview for mental status with a score of 3 out of 15. A score of 0-7 indicates R25 has severe cognitive impairment. On 05/06/25 at 01:43 PM, V1 Administrator was inquired of R25's PASARR screening. V1 said, R25 did not have a PASARR assessment done. On 05/07/25 at 11:19 AM, review of R25's electronic medical record, no assessment was found. V10 Admissions Director initiated R25's PASARR screening upon surveyor request on 05/06/2025. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25 was admitted to the facility on [DATE]. Upon review of R2's medical record, there was no documentation of a PASARR (preadmission screening resident review) upon admission. Upon review of R25's electronic medical record, there was no documentation of a PASARR (preadmission screening resident review) upon admission. R25's current physician orders document the following medications- Olanzapine Oral Tablet 5 MG Give 1 tablet by mouth at bedtime. (Antipsychotic medication) and Mirtazapine Oral Tablet 30 MG Give 1 tablet by mouth at bedtime for depression, anxiety. (Antidepressant medication). The facility did not provide a policy regarding PASARR screening. Resident #25 PASARR 05/06/25 01:43 PM V1 said, R25 did not have a PASARR assessment done. 05/07/25 11:19 AM No assessment, initiated upon surveyor request on 05/06/2025.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess pressure ulcer for 1 (R105) of 4 residents reviewed for pressure ulcers in a sample of 50. Findings include: R105 is an [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: congested heart failure, atrial fibrillation, and osteomyelitis of the vertebral, sacral, and sacrococcygeal region. On the (MDS) Minimal Data Set assessment of 4/4/2025, section C, the BIMS (Brief Interviewed Mental Status) score was 11/15 and indicates moderate cognitive impairment. On MDS of 4/4/2025, GG section R105 requires partial/moderate assistance - Helper does less than half the effort. The helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort. Behavior Section E dated 1/24/205 and 2/10/2025 showed no refusal care behavior. On 5/5/2025 at 10:36 AM, R105 was observed in his room, upset because staff members just told him that he had to go to the hospital to treat his buttocks wound and did not want to talk about his care and just said, I don't feel good. Record review of wound treatment of the sacrum for April 2025 and May 2025, R105 only refused treatment on one day, dated 4/5/2025. Record review of 5/5/2025 hospital records read: R105 feels 'lousy and stated he is in pain and the sacrum wound is painful, moving around makes the pain worse. V19 (Hospital Physician) assessment described the sacrum wound as unstageable but I can see muscle, it is foul smelling with purulent discharge. On 05/05/25 at 2:32 PM, V7(Registered Nurse) said, R105 was transferred to the hospital because of losing weight and refusing care, wound worsening, and pain. I did not do the dressing today, but the DON (V2) and V14 (Certified Nursing Assistant) changed the dressing, and V18 (NP) called and gave the order to send the resident to the Emergency Department. When questioned, V7 (RN), what R105's weight-loss was and how the wound appeared, the nurse indicated she didn't know how much the resident lost and could not describe the wound because she had not seen it. The surveyor asked if R105 was her resident. V7 said it was, but she had received directives from the DON and followed V18's NP orders. The surveyor asked how much the resident ate today, but V7 was not able to provide the information either. On 5/6/2025 at 8:57 AM, requested skin assessment of R105's coccyx area to V6 (Wound Care Nurse) for the month of January 2025, and no skin assessment was provided upon request. V6 said, R105 did not have a current coccyx wound, and the 1/15/2025 wound assessment is a new stage 4 facility-acquired coccyx wound. V6 said that CNAs (Certified Nursing Assistants) assess the residents twice a week during showers and incontinence care and will notify the nurses and me if there is a skin impairment noted during care. I am not sure how long R105's wound was present before I was notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/6/2025 at 11:30 AM, V2 (Director of Nursing) said, nurses are not expected to complete skin assessment, and the facility no longer enters skin assessment as an order. Certified nursing assistants will notify nurses or the wound care nurse if there is any skin impairment. The surveyor requested facility provide shower sheets from January to the current, and skin assessment, but only one skin evaluation dated 4/8/2025 was provided. Coccyx wound assessment dated [DATE] described the initial assessment as a Coccyx stage 4, and V2 was not able to discuss why treatment and assessment were not done sooner. The surveyor asked V2 if the resident came in with an existing pressure ulcer. V2 stated, No, it is facility-acquired. On 5/6/2025 at 12:40 PM, V12 (Licensed Practical Nurse) said that V14 (Certified Nursing Assistant Supervisor) called her to assist with R1's wound around 9:00 AM on 5/5/2025. V12 said, I am assigned to R105 sometimes, but the floor nurse was not available, so I went in the room to help. The wound looked big, and with a lot of drainage that looked like pus, and with an odor. On 5/6/2025 at 4:57 PM, V13(Family Member) said, I received a phone call on Monday from the facility that (R105) was going to the hospital because of the wound worsening, pain, and failure to thrive. I know that (R105) did not want to turn and move because of the pain. I spoke with the physician from the hospital today and indicated that the buttocks wound will never heal. That is what my uncle will have to live with. On 5/7/2025 at 1:45 PM, V18 (Nursing Practitioner) said her company recently started to provide services to the facility starting April 2025 and had to debride the wound a couple of times for non-viable tissue necrotic (dead) tissue. On 04/30/2025, V18 provided a description of the sacrum wound to have exposed tissue and be able to see Bone, Muscle,/Fascia after the debridement. V18 said, I used lidocaine numbing medication during the wound procedure and believes that R105 has other pain medication ordered, but could not provide which pain medication to the surveyor. When questioned on how long a wound would take to get to a stage 4, V18 said that it is not an easy question to answer because R105 had some comorbidities to take in consideration. On record review of the May TAR (Treatment Administration Record), V7 entered NN on the electronic treatment record for 5/5/2025, which means see nurses' notes, but no wound nurses' notes were recorded or provided to the surveyor when requested. On the electronic medication record, pain medication was ordered until 5/2/2025. Physician orders read: Acetaminophen Tablet 325 MG. Give 2 tablets by mouth every shift for pain (give 1 hour before treatment). There were no pain medications provided as needed for pain for the month of April 2025. R105's wound of the Coccyx initial assessment dated [DATE], and there are no weights completed since 4/9/2025 to determine percentage weight loss. When a pressure ulcer list was requested by the survey team on 5/5/25, R105 was not included on the pressure ulcer list until requested again by the survey team to provide a more precise list. Surveyors asked V6 about the discrepancy, but only indicated that it was because the resident was being discharged the same day as the start of the annual survey. On 5/06/2025 at 4:11 AM, V1(Administrator) provided the policy title, Skin Care Regimen and Treatment Formulary, reviewed dated 1/24/2024. Which reads in part (but not limited to), Policy Statement It is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for residents with skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures 1. Charge nurses must document in the Electronic Health Record any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained from the patient's physician. 2. Routine daily wound care treatment/ dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician. Pressure Injuries: III. Stage 3 and Stage 4: Clean Wound Bed: Calcium Alginate, Thera Honey, Hydrocolloid, Xeroform Gauze