

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/13/2024
NAME OF PROVIDER OR SUPPLIER  Grove Health & Rehab Ctr, The		STREET ADDRESS, CITY, STATE, ZIP CODE  873 Grove Street Jacksonville, IL 62650	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32874</p> <p>Based on observation, interview and record review the facility failed to provided assistance during feeding in a dignified manner for 5 of 32 residents (R26, R39, R50, R54 and R91) reviewed for dignity in the sample of 61.</p> <p>Findings include:</p> <p>1. On 09/09/24 at 11:54 AM during the the noon meal at the first floor dining room the first tray was served at 11:36 AM. The meal consisted of beef stroganoff, Brussels sprouts or green beans, roll, white confetti cake with white frosting. V5, Certified nursing Assistant (CNA) standing in the middle of assisted feeding tables that form a circle. V5 standing up feeds resident a bite off of a spoon , sanitizes hands then feds another resident bite of food with a spoon. This includes R26 and R39.</p> <p>On 9/9/2024 at 12:14PM V6, CNA enters the circle and starts feeding R26 while standing up and when providing drink has to reach to get cup to R26's mouth.</p> <p>R26's Physician order (PO) dated 9/2024 document s regular diet mechanical soft texture, thin consistency.</p> <p>R26's care plan dated 6/10/2024, documents self care deficit as evidenced, need assistance with Activity of Daily Living (ADL)'s , intervention dated 6/10/2024 eating - one person physical assist required; occasionally feeds self finger foods or takes a drink but usually dependent on staff to feed.</p> <p>R26's Minimum Data Set (MDS) dated [DATE] documents R26 is rarely/never understood</p> <p>2. R39's PO dated 9/2024 documents regular diet pureed texture, nectar consistency.</p> <p>R39's care plan dated 6/9/2024 documents self care deficit needs assistance with ADL's related to dementia, impaired decision making and weakness. R39's care plan documents intervention for eating; dated 8/27/2024 one person physical assist required.</p> <p>R39's MDS dated [DATE] documents R39 is severely cognitively impaired.</p> <p>40650</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 09/09/2024 at 12:20 PM, V9, CNA, was standing up feeding R54 at lunch time.</p> <p>On 09/10/2024 at 1:30 PM, R54 stated that they feed him and sometimes they don't sit down.</p> <p>R54's Physician's order sheet, dated 09/2024, documented a diagnosis of Metabolic Encephalopathy and Type 2 Diabetes.</p> <p>R54's MDS, dated [DATE], documented that his cognition was intact and that he was dependent upon staff for eating.</p> <p>R54's Care Plan, dated 8/27/2024, documented, Eating - One person physical assist required as an intervention.</p> <p>4. On 09/09/2024 at 12:25 pm, V8, CNA, was standing up feeding R50 her lunch.</p> <p>R50's Physician's order sheet, dated 09/2024, documented diagnoses of Alzheimer's and Dementia.</p> <p>R50's MDS, dated [DATE], documented that her cognition was severely impaired and that she was dependent upon staff for eating.</p> <p>R50's Care Plan, dated 7/3/2024, documented, Eating - One person physical assist required. as an intervention.</p> <p>5. On 09/09/2024 at 12:25 pm, V8, CNA, was standing up feeding R91 her lunch.</p> <p>R91's Physician's order sheet, dated 09/2024, documented a diagnosis of dementia.</p> <p>R91's MDS, dated [DATE], documented that her cognition was severely impaired and that she was dependent upon staff for eating.</p> <p>R91's Care Plan, dated 8/12/2024, documented, Eating - Provide set up, encourage self feeding, assist to finish most times.</p> <p>On 9/12/2024 at 9:25 AM, V28, CNA, stated that when she is feeding a resident in the dining room, she always sits down.</p> <p>On 9/12/2024 at 9:27 AM, V9, CNA, stated that when they are feeding residents they are to sit down.</p> <p>On 9/12/2024 at 9:30 AM, V11, CNA stated that they are to be sitting down while feeding a resident during a meal.</p> <p>The facility's policy, Providing Assistance with Meals, issue date 9/12/2024, documented, 1. Not standing over residents while assisting them with meals.</p> <p>The pamphlet, Residents' Right for People in Long-term Care Facilities, dated 3/2017, documented, Your facility must provide services to keep you physical and mental health, and sense of satisfaction. It continues, Your facility must make reasonable arrangements to meet your needs and choices.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50908</p> <p>Based on interviews, observations, and record reviews the facility failed to provide eating assistance for 1 out of 8 residents (R323), reviewed for feeding assistance in a sample of 61.</p> <p>Findings include:</p> <p>R323 was admitted to the facility on [DATE] with diagnosis of, in part, fracture of unspecified part of neck of left femur, unspecified fall, unspecified dementia.</p> <p>R323's Minimum Data Set (MDS) dated [DATE] documents R323 is severely cognitively impaired with a brief interview of mental status score of 3. R323's MDS further documents R323 requires supervision or touching assistance with eating.</p> <p>R323's Care Plan dated 7/19/24 documents R323 has a self-care deficit as evidenced by needing assistance with activities of daily living (ADLs) with an intervention for eating to provide set-up and assist as needed.</p> <p>On 9/9/2024 at 11:48 AM, R323 was not touching the meal and received no prompting by staff to eat, beef stroganoff on noodle, brussel sprouts, roll and white confetti cake with frosting.</p> <p>On 9/9/2024 at 12:00PM, R323's table mate prompted R323 to eat. At 12:18 PM, table mate placed cake in front of R323 and put a fork in cake for her.</p> <p>On 9/09/2024 at 12:30 PM, R323 was not prompted by any staff member to eat her food. R323 ate a couple bites of cake.</p> <p>R323 ' s weight documentation on 7/03/2024, documents the resident weighed 125.4 lbs. On 09/01/2024, the resident weighed 116.2 pounds which is a -7.34% loss. On 9/11/24 at 8:55 AM, V7, certified nursing assistant, CNA, took R323 to the scale and R323 weighed 114 pounds making her total a 9.09% weight loss since 7/3/2024.</p> <p>On 9/11/2024 at 9:10 AM V21, Certified Nurse Assistant (CNA), stated she has noticed R323 has not been eating much but not aware of any weight loss and R323 does get nutrition shakes but not sure on anything else they are doing for her.</p> <p>On 9/11/2024 at 12:10 PM, V3, assistant director of nursing, ADON, stated the dietician is notified of all weights, including weight loss every month. V3 stated R323's appetite decreased when she was diagnosed with Covid about three weeks ago. V3 stated he was not aware that R323 continued to lose weight, he thought she was doing better. V3 stated he would have expected to be notified of R323's weight loss. V3 stated the staff had tried to move R323 to the assisted feeding table not too long ago to help her but her daughter did not want her to be moved.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/11/2024 at 12:26 PM, V18, dietician, stated she was not aware of R323's increased weight loss. V18 stated the facility sends her a report at the beginning of each month and will often start interventions that she will review but no new interventions were started for this month that she knew of. V18 stated she would recommend R323 to be re-evaluated and have more assistance while eating.</p> <p>The facility's policy on Providing Assistance with Meals printed 9/12/24 documents, All residents will be encouraged to eat in the dining room. Nursing staff and/or Feeding Assistants will serve resident trays and will help residents who require assistance with eating.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33112</p> <p>Based on interview, observation and record review, the facility failed to ensure personal use items were within reach and provide an environment free of clutter to prevent falls and injury for 1 of 6 residents (R12) reviewed for accidents in the sample of 61. This failure resulted in R12 sustaining a cervical fracture, wearing a neck brace from 4/8/24 until 6/18/24, and requiring 9 sutures to his forehead.</p> <p>Findings include:</p> <p>R12's Admission Record, print date of 9/11/24, documents that R12 was admitted on [DATE] with diagnoses of Repeated Falls, Mild Cognitive Impairment, and Palliative Care.</p> <p>R12's Minimum Data Set, dated [DATE], documents R12 is cognitively intact, requires partial to moderate assistance from staff with sitting to standing position and standing and walking, and occasionally incontinent of bowel and bladder.</p> <p>R12's Health Status Note, dated 4/8/24 at 9:31 PM, documents, Heard noise down the hall. Resident observed laying on floor on right side with head on bathroom floor. Resident states he was going to use urinal at bedside and lost balance and fell . Laceration noted to right eyebrow area and forehead. VS (vital signs): temp (temperature) 98.7, pulse 64, resp.(respirations) 18 B/P (blood pressure) 130/60, SPO2 (oxygen saturation level) 96. Resident denies discomfort except for head Towels placed to bleeding areas. Ambulance called for transport to ER (emergency room ) for Evauation (sic). Hospice notified resident needs to go to ER and okay given. POA (Power of Attorney) notified. RN (Registered Nurse) on call notified.</p> <p>R12's Health Status Note, dated 4/9/24 at 4:09 AM, documents, Resident returned to facility per POA. Staff assisted resident to room and to bed. Alert and oriented x3. Neck Brace in place. Message left with Appt. (appointment) Scheduler to f/u (follow up) with Spine specialist. PRN (as needed) Morphine given.</p> <p>R12's Fall Investigation, undated, documents, Heard noise down hall. Resident observed laying ion floor in room on right side with head laying on bathroom floor. Laceration noted to right eyebrow area and forehead. Resident states stood up out of bed to use urinal and lost balance and fell . Appears resident grabbed hold of bedside table since bedside table upside down and under resident and urinal on bathroom floor. Resident stats he has gotten up out of bed to use urinal. Resident noted urinal was on the bedside table 2 feet from him, so he got up to grab urinal on his own. Resident then stated that he tried to pull the table to him and it got farther from him instead, causing him to fall forward towards bathroom. It continues, Staff state the CNA (Certified Nurse Assistant) had put resident to bed at approximately 8:30 PM, an hour prior to fall, and thinks she forgot to put bedside table closer to the bed. It continues, resident states he does use his urinal at night with no assistance, and staff agree with this statement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R12's ED (Emergency Department) Physician Notes, dated 4/8/24, documents, Associated Diagnoses: C5 cervical fracture; laceration of forehead. It continues, Laceration: 3 cm (centimeters) in length R (right) forehead. Skin closure: 9 sutures.</p> <p>R12's Cervical Spine 2 views, dated 4/9/24, documents, Impression: Interval improved anatomic alignment of the anterior superior corner fracture fragment of C5 vertebral body since prior CT (computed tomography scan) study.</p> <p>R12's Health Status Note, dated 5/28/24, documents, Resident returned from MD (Medical Doctor) with progress note stating he must wear his cervical collar at all times for another 4 weeks. follow up appt (appointment) in 1 month.</p> <p>R12's Health Status Note, dated 6/18/24, documents, orders received per hospice to d/c (discontinue) neck brace.</p> <p>On 9/12/24 at 12:05, V3, Assistant Director of Nurses (ADON), stated the aides should place the bed side table next to the resident so they can reach their items.</p> <p>On 9/10/24 at 10:18 AM. R12's room was entered, by the bathroom door the is are 2 larger oxygen cylinders in a cart and 4 smaller oxygen cylinders not in a cart sitting on the floor. The 4 smaller cylinders have a thin metal tube that extends upward approximately 2 1/2 inches from the top of the cylinder. There is no cap on these metal tubes to prevent injury if someone fell on to them. These 4 oxygen cylinders also are not secured to prevent being knocked over and causing injury.</p> <p>ON 9/10/24 at 10:25 AM, V14 Licensed Practical Nurse, was questioned why the oxygen cylinders were in R12's room, V14 stated, Those are from hospice. I am not sure why they are here.</p> <p>On 9/10/24 at 10:30 AM, V2 , Director of Nurses, (DON), was questioned about the oxygen tanks in R12's room, V2 stated, Those are still there? (The hospice) company delivered them for (R12). This (hospice) brings them for their patients. I had sent an email to them to come and pick them up.</p> <p>R12's Health Status Note, dated 9/9/24 at 6:35 AM, documents, Writer called to (R12's) room at 630 AM. (R12) was laying on the floor head leaning on O2 (oxygen) tanks that were against the wall by the bathroom door. Small dresser next to bathroom door knocked over. (R12) stated he had to go to the bathroom and lost his balance. He grabbed the dresser knocking it and the belongings on top of it over. (R12) stated he didn't fall that hard due to grabbing dresser. He denies any pain or discomfort. ROM WNL (range of motion within normal limits). No bruising noted at this time. VS WNL (vital signs within normal limits). PCP (primary care provider) made aware. Neuro (neurology) checks initiated.</p> <p>R12's Health Status Note, dated 9/9/24, documents, IDT (intradisciplinary team) met to discuss recent fall. RCA (root cause analysis): Resident is often noncompliant and transfers on his own, even though he is an assist of 1. Resident got up on his own to use restroom and fell . Resident needs cues to remind him to not get up unassisted. Intervention: 'Call don't fall' sign posted</p> <p>Care plan updated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R12's Health Status Note, dated 9/10/24, documents, Continues on FVS/Neuros (follow up vital signs / neurology checks). Resident is a/o (alert and oriented) x 4 per norm (normal). Denies pain or discomfort. Bruising to right shoulder, left hand and right foot/ankle r/t (related to) fall reported by Hospice CNA (Certified Nurse Assistant) during resident shower.</p> <p>R12's Care Plan documents, Fall risk, weakness, terminal condition, under hospice care, has been having multiple falls at home, prior to admission, history of TIA (trans ischemic attack) with some memory deficits, may be incont (incontinent), (R12) is non-compliant at times will try to get up without help Date Initiated: 01/21/2024. Intervention: Keep environment free from clutter. Date Initiated: 01/21/2024 Revision on: 01/21/2024. Keep personal belongings within reach Date Initiated: 01/21/2024.</p> <p>The policy Accidents &amp; Incidents, dated 7/1/23, documents, 4. Investigate and follow up action: A. The charge Nurse must conduct an immediate investigation of the accident / incident and implement immediate appropriate interventions to affected parties.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40650</p> <p>Based on observation, interview and record review, the facility failed to perform complete incontinent and peri care for 4 of 4, (R4, R29, R232, R273) residents, reviewed for incontinence, in a sample of 61.</p> <p>Findings include:</p> <p>1. On 09/10/2024 at 10:00 AM, V9, Certified Nurse Assistant (CNA), with gloved hands, pulled back R273, incontinent brief, and cleansed her right groin, then left groin and then down the center of R273's labia with rinse free peri wash and a wet washcloth. These areas were not dried and R273 was then rolled on to her right side. V9, CNA, then took a wet washcloth, that had the rinse free peri wash on it and cleansed R273's right hip and then cleansed, R273's rectal area from back to front. There were soapy suds of the rinse free wash on R273's left hip and left buttocks when V9 placed a new incontinent brief under her. R273 was then rolled on to her left side, and V9 cleansed R273's right hip with the no rinse peri wash and then fastened the clean incontinent brief without drying the right hip.</p> <p>R273's physicians order sheet, dated 9/1/24, documented diagnoses of Urinary tract infection and Hemiplegia and Hemiparesis following cerebral infraction affecting the right dominate side. It also documented that R273 was admitted to the facility on [DATE].</p> <p>R273 Baseline care plan, dated 9/1/2024, documented, Assist with peri-care if incontinent, to help keep resident clean dry &amp; odor free.</p> <p>R273's Minimum Data Set, dated dated [DATE], was incomplete, during this investigation.</p> <p>On 9/12/2024 at 9:25 AM, V28, CNA, stated that the peri wash should be rinsed off and that all areas should be dried after incontinent care. V28 also stated that when doing incontinent care, she would cleanse from front to back and not back to front.</p> <p>On 9/12/2024 at 9:27 AM, V9, CNA, stated that when they do incontinent care, that they should rinse off the peri wash and dry all areas that were cleaned and that when incontinent care is done from front to back.</p> <p>On 9/12/2024 at 9:30 AM, V11, CNA stated that when incontinent care is done, that she would clean from front to back and that she dries all areas that were washed.</p> <p>50908</p> <p>2)</p> <p>R323 was admitted to the facility on [DATE] with diagnosis of, in part, fracture of unspecified part of neck of left femur, unspecified fall, unspecified dementia.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R323's MDS dated [DATE] documents R323 requires substantial/maximal assistance with toileting hygiene.</p> <p>R323's Care Plan dated 7/19/24 documents R323 is at skin risk for weakness with decreased mobility related to medical condition and may be incontinent with an intervention to assist with peri-care if incontinent, to help keep resident clean dry and odor free.</p> <p>On 09/11/24 at 9:10 AM, V7, certified nursing assistant, CNA, provided peri-care to R323 after having a bowel movement on the toilet. V7 stood R323 up to walker with a gait belt. V7 did not change her gloves, nor did she perform hand hygiene after wiping R323. V7 proceeded to pull R323's brief and pants up with the same dirty gloves. V7 did not dry R323's peri region off after wiping her with a wet towel.</p> <p>32874</p> <p>3. On 9/11/2024 at 11:30AM during incontinent care V21, Certified Nursing assistant (CNA) with disposable washcloths cleansed R4's R groin, l groin, inner thighs , then turned to left side. V21 did not separate or cleanse the labia. V21 did not dry R4's peri area prior to turning R4. V21 CNA then swiped disposable washcloth from front to back with R4 on left side. V 21 then cleanse inner thighs and buttocks , V21 did not dry R4 prior to putting adult diaper on R4.</p> <p>R4's care plan dated 8/15/2024 documents R4 is at risk of urinary tract infection due to history of (UTI). R4's care plan dated /15/2024 documents incontinent of bowel/bladder. R4's care plan documents the following intervention:</p> <p>encourage and assist to toilet routinely and provide peri-care when incontinent.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] documents R4 is always incontinent</p> <p>The facility Incontinence Care policy dated 7/1/2023 documents all incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/odor. Incontinence care will be provided as required. The policy documents wash all soiled skin areas and dry very well.</p> <p>4. On 9/11/2024 at 10:44AM during incontinent care V19, CNA filled basin with warm. V19 then squirted body cleanser in the basin and placed on bedside table .V19 removed adult diaper which was wet as verified by v19, CNA. After cleansing R29 front including peri area and inner thighs V19 CNA did not rinse or dry R29 . V19 than assisted R29 to roll on right side . R19 took clean towel and placed in basin then cleanse R29. V19 started cleansing from the back to the front starting at rectal area . V19 then dried R29 rectal area and buttocks with dry towel going from the rectal area to the vaginal area. V19 did not rinse R29 prior to drying back are with towel</p> <p>R29's care plan dated 6/22/2022 documents R29 is incontinent of bowel and bladder, and needs staff assistance with toileting. R29's care plan documents the intervention to encourage and assist to toilet routinely and provide peri-care when incontinent.</p> <p>R29's MDS dated [DATE] documents R29 is frequently incontinent of urine</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility bottle label DermaVera documents body cleanser is suitable for skin and moisture the label documents apply a small amount , massage into a rich full lather . Rinse.</p> <p>880- After providing incontinent care V19. do with same gloves provided incontinent care touched curtain and barrier V19 provided incontinent cream packet with unclean gloves and applied barrier cream to R29's buttocks and rectal area with the same gloves used to provide incontinent care to R29.</p> <p>On 9/12/2024 at 7:52AM V21, CNA stated when doing incontinent care on a female she was trained to clean peri area including to separate and cleanse the labia.</p>		

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NAME OF PROVIDER OR SUPPLIER  Grove Health & Rehab Ctr, The		STREET ADDRESS, CITY, STATE, ZIP CODE  873 Grove Street Jacksonville, IL 62650	
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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50908</p> <p>Based on interviews, observations, and record reviews the facility failed to assess, monitor, and implement interventions to prevent weight loss in 1 out of 5 residents, R323, reviewed for nutrition in a sample of 61. This failure resulted in R323 acquiring a 9.09% weight loss in less than 3 months.</p> <p>Findings include:</p> <p>R323 was admitted to the facility on [DATE] with diagnosis of, in part, fracture of unspecified part of neck of left femur, unspecified fall, unspecified dementia.</p> <p>R323's MDS dated [DATE] documents R323 is severely cognitively impaired with a brief interview of mental status score of 3. R323's MDS further documents R323 requires supervision or touching assistance with eating.</p> <p>R323's Care Plan dated 7/19/24 documents R323 has a self-care deficit as evidenced by needing assistance with activities of daily living (ADLs) with an intervention for eating to provide set-up and assist as needed.</p> <p>R323's weight documentation on 7/03/2024, documents R323 weighed 125.4 lbs. On 09/01/2024, R323 weighed 116.2 pounds which is a -7.34% loss. On 9/11/24 at 8:55 AM, V7, certified nursing assistant, CNA, took R323 to the scale and R323 weighed 114 pounds making her total a 9.09% weight loss since 7/3/2024.</p> <p>On 9/11/2024 at 9:10 AM, V21, CNA, stated she has noticed R323 has not been eating much but not aware of any weight loss and R323 does get nutrition shakes but not sure on anything else they are doing for her.</p> <p>On 9/11/2024 at 12:10 PM, V3, assistant director of nursing, ADON, stated the dietician is notified of all weights, including weight loss every month and has access to all the resident's charts. V3 stated R323's appetite decreased when she was diagnosed with Covid about three weeks ago. V3 stated he was not aware the R323 continued to lose weight, he thought she was doing better. V3 stated he would have expected to be notified of R323's weight loss. V3 stated the staff had tried to move R323 to the assisted feeding table not too long ago to help but her daughter did not want her to be moved.</p> <p>On 9/11/2024 at 12:26 PM, V18, dietician, stated she was not aware of R323's continued weight loss. V18 stated the facility sends her a report at the beginning of each month and will often start interventions that she will review but no new interventions were started for this month that she knew of on R323. V18 stated R323 was started on nutritional shakes and Med Pass for supplementations on 8/29/24. V18 stated she was not notified of the further weight-loss since 9/1/24 but she would have expected to be notified of any. V18 stated she would recommend R323 to be re-evaluated and to be provided more assistance while eating.</p> <p>(continued on next page)</p>		

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F 0692  Level of Harm - Actual harm  Residents Affected - Few	The facility's Weight Assessment and Intervention policy dated 7/1/23 documents, The dietician will review the Weight Record at least monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. It further documents, The threshold for significant unplanned and undesired weight loss will be based on the following criteria .3 months - 7.5% weight loss is significant; greater than 7.5% is severe.		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33112</p> <p>Based on interview and record review, the facility failed to provide Physician prescribed medication for 1 of 4 residents (R223) reviewed for medication. This failure resulted in R223 missing 28 doses of oxcarbazepine (seizure medication) and having 10 seizures between 8/2/24 and discharge to the hospital on 8/11/24.</p> <p>Findings include:</p> <p>R223 was admitted on [DATE] with diagnoses of metabolic encephalopathy, convulsions, schizophrenia.</p> <p>R223 Minimum Data Set, MDS, dated [DATE], documents that R223 is cognitively intact.</p> <p>R223's Health Status Note, dated 7/19/2024 4:45 PM, documents, (V30, R223's Neurologist) called gave order to start Trileptal 300 mg (milligram) i bid (twice a week) x i (one) week then increase to Trileptal 600 mg i bid for break through seizures. Dr said next time he sees res (resident) in clinic he will probably start the D/C (discontinue) process of Keppra. (V30) said he sent order to pharmacy for res (resident).</p> <p>R223's Health Status Note, dated 8/2/2024 12:50 PM, documents, Resident continue with seizures back to back resident appears very tired and weak NP (Nurse Practitioner) here present in the facility witness these episode want resident to recieve (sic)I V (Intravenous) Ativan obtain order to tranfer (sic) to hospital POA (Power of Attorney) updated.</p> <p>R223's Health Status Note, dated 8/2/2024 20:30, returned from ER (emergency room ) per facility staff, was having seizure in facility van, lasted 3 minutes, remained alert and responded correctly when seizure subsided, returned to with (hall) staff x 2, bp (blood pressure)100/66 p (pulse)100 r (respiration) 20 t (temperature) 97.4, resident rec'd (received) labs and cts (computed tomography scan) while in er, new order for cefdinin (sic) for uti (urinary tract infection)/pneumonia starting 8/3 with titrating doses of prednisone, resident had poor appetite but did intake fluids, full body lift to bed, recid (sic) iv ativan and iohexol (sic) and ceftriaxone while in er</p> <p>R223's Health Status Note, dated 8/3/2024 6:45 PM, documents, Resident continue with seizures x3 updated MD (Medical Doctor).Remain on ABT (antibiotic) for UTI no adverse reaction encouraging fluids and POA</p> <p>R223's Health Status Note, dated 8/10/2024 6:30 PM, documents, resident yelled out in dining room that she was going to have seizure, had small seizure for 30 seconds, remained with eyes open during seizure, was quiet and able to respond after,</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R223's Health Status Note, dated 8/11/2024 09:35 AM, documents, Resident in the Dining room eating breakfast staff noted resident seizing (sic) writer went to resident to observe and give support seizure lasted about 2 minutes .Resident was easy to arouse offer meds (medications) due to resident alertness request meds to be crushed . Took meds with no problems .assist to bed per resident request. Updated POA of this incident and called (V31, R223's neurologist) on call MD was (V32, neurologist) update on resident reviewed med list MD stated she will call back today</p> <p>R223's Health Status Note, dated 8/11/2024 4:39 PM, documents, (V32) on call for (V31) return call with new orders for seizure .Updated POA with new orders and medication. (new order was for oxcarbazepine 600 mg bid)</p> <p>R223's Health Status Note, dated 8/11/2024 5:17 PM, documents, Resident experienced seizure during dinner and was sent to (local hospital) via EMS (Emergency Medical Services) MD and POA notified</p> <p>R223's Health Status Note, dated 8/11/2024 11:01 PM, documents, called (local hospital) for update, resident will be transferring to (Regional Hospital) when bed available due to resident has not returned to baseline</p> <p>R223's Health Status Note, dated 8/12/2024 1:16 PM, documents, notified by (Regional Hospital) that resident will be going to another facility at daughter request to be closer to spfld ([NAME]).</p> <p>R223's Medication Administration Record (MAR), documents, Trileptal Oral Tablet (Oxcarbazepine) Give 300 mg by mouth two times a day for Seizures for 7 Days</p> <p>-Start Date07/20/2024 0600 -D/C Date07/28/2024 0942.</p> <p>R223's MAR, documents, Trileptal Oral Tablet (Oxcarbazepine) Give 600 mg by mouth two times a day for seizures -Start Date07/27/2024 4:00 PM -D/C Date07/28/2024 0942.</p> <p>R223's MAR, documents, OXcarbazepine Oral Tablet 300 MG (Oxcarbazepine) Give 300 mg orally two times a day related to EPILEPSY, UNSPECIFIED, NOT</p> <p>INTRACTABLE, WITHOUT STATUS EPILEPTICUS (G40.909) until 08/18/2024 11:59 PM -Start Date08/12/2024 0800 -Hold Date from 08/12/2024 0031 to 08/14/2024 0030.</p> <p>R223's Hospital Record, signed date of 8/12/24, documents, Assessment ? Plan (R223) is a [AGE] year old female, with history of bitemporal seizures, who presents with breakthrough seizures. (Hospital) Neurology consulted for medical management to breakthrough seizures. It appears that her seizures were likely due to sub optimal management of her medications while she was in the nursing home. At this time I will resume the medication she was on in the nursing home with the addition of oxcarbazepine which she was prescribed by (V31).</p> <p>R223's Hospital Record, print date of 8/13/24, documents, (Hospital Neurology Consult Note, documents, Reason for Admission: Seizure. HPI (History of Present Illness) She is has been having seizures at the nursing home for the past few weeks which have been increasing in frequency. Upon interview with the nursing home it appears that she was on a different dose of medications than those that were recommended when she last saw (V31) in the clinic. it continues, It is unclear why she was not taking the oxcarbazepine 600 mg bid prescribed to her.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/12/24 at 11:28 AM, V2, Director of Nurses, stated, I have looked into how the oxcarbazepine was discontinued. I reached out to pharmacy and when (V33, Licensed Practical Nurse) looked at the order she only read the first part of 300 mg for seven days and went into the computer and discontinued the medication.</p> <p>On 9/12/24 at 11:39 AM, (V34, Medical Director) stated, Any medication ordered should be given as ordered. (R223) is a very complicated case not getting the oxcarbazepine did not help her but I am unable to say if it harmed her because she was such a complicated case.</p> <p>On 9/12/24 at 12:01 PM, V1, Administrator, stated that he does not know what policy would work for this medication error but he does expect that medications should be given as they are prescribed by the Physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33112</p> <p>Based on interview, observation, and record review, the facility failed to discard expired blood glucose monitor control solutions for 4 of 4 (R10, R14, R48, R84) reviewed for medication storage in the sample of 61.</p> <p>Findings include:</p> <p>On [DATE] at 10:53 AM, the North South medication cart was reviewed with V14 Registered Nurse, The blood glucose machine High Control Solution expired on [DATE].</p> <p>The, undated, facility provided list of residents that receive blood glucose monitoring on the north south hall documents R14, R10, R84 and R48 all receive blood glucose monitoring.</p> <ol style="list-style-type: none"> <li>1. R84's Physician Order, dated [DATE], documents, Accu check (blood glucose check) four times a day relate to type 2 diabetes mellitus without complications.</li> <li>2. R14's Physician Order, dated [DATE], documents, Accu check at bedtime for DM (Diabetes Mellitus).</li> <li>3. R10's Physician Order, dated [DATE], documents that (R10) will have her blood sugar checked three times a day due to Diabetes Mellitus.</li> <li>4. R48's Physician Order, dated [DATE], documents, accucheck in the morning for Diabetes.</li> </ol> <p>On [DATE] at 11:08 AM, V1, Administrator, stated that the nurse doing the calibration should make sure the controls are not expired.</p> <p>The policy Obtaining a blood glucose level procedure, undated, documents, 4. Ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacture or this facility.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40650</p> <p>Based on observation interview and record review, the facility failed to perform hand hygiene before donning and after doffing gloves, prior to donning personal protective equipment (PPE), failing to prevent cross contamination during care and donning PPE prior to entering a enhance barrier precaution labeled resident room, for 4 of 4 (R29, R58, R273 and R323) residents reviewed for infection control, in a sample of 61.</p> <p>Findings include:</p> <p>1. On 09/10/2024 at 10:00 AM, After R273 was transferred into her bed by V9 and V22, both Certified Nurse Assistants (CNA's). V22 doffed her gloves and reapplied a new pair of gloves without benefit of hand hygiene and removed the cover and the sling from underneath R273. V9, CNA, with gloved hands, performed perineal care and once completed, both V9 and V22, doffed gloves and without benefit of hand hygiene, both donned a new pair of gloves. V9, CNA, then continued to provide perineal care.</p> <p>R273's physicians order sheet, dated 9/1/24, documented diagnoses of Urinary tract infection and Hemiplegia and Hemiparesis following cerebral infraction affecting the right dominate side.</p> <p>On 9/12/2024 at 9:25 AM, V28, CNA, stated that hand hygiene is done when you take off your gloves and before you put them on.</p> <p>On 9/12/2024 at 9:27 AM, V9, CNA, stated that hand hygiene is done before you put on gloves and after they are taken off.</p> <p>On 9/12/2024 at 9:30 AM, V11, CNA stated that hand hygiene is done between glove changes and before you put on gloves.</p> <p>32874</p> <p>2. On 9/11/1014 at 10:42AM V20, Certified Nursing Assistant (CNA) donned gloves and did not sanitize hands prior to donning gloves, V20 donned gown and did not secure the gown by fastening the ties on the gown. V20 entered R58's room and pulled back adult brief during the process V20's gown is falling forward exposing V20's top and the gown is touching R58's bed. V20 stated i forgot to tie my gown. There is a sign posted outside R58's room, the facility sequence for putting on Personal Protective Device (PPE) undated documents gown fully cover torso from neck to knees, area to end of wrists , and wrap around the back.</p> <p>R58's record documents R58 is on Enhanced barrier precaution related to Colostomy.</p> <p>3. On 9/11/2024 at 10:44AM during incontinent care V19, CNA with same gloves provided incontinent care did not change gloves and touched the curtain and barrier cream packet. V19 CNA then applied barrier cream to R29's buttocks and rectal area with the same gloves used to provide incontinent care to R29.</p> <p>50908</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4)</p> <p>R323 was admitted to the facility on [DATE] with diagnosis of, in part, fracture of unspecified part of neck of left femur, unspecified fall, unspecified dementia.</p> <p>R323's MDS (Minimum Data Set) dated 8/26/24 documents R323 requires substantial/maximal assistance with toileting hygiene.</p> <p>R323's Care Plan dated 7/19/24 documents R323 is at skin risk for weakness with decreased mobility related to medical condition and may be incontinent with an intervention to assist with peri-care if incontinent, to help keep resident clean dry and odor free.</p> <p>On 09/11/24 at 9:10 AM, V7, certified nursing assistant, CNA, provided peri-care to R323 after having a bowel movement on the toilet. V7 stood R323 up to walker with a gait belt. V7 did not change her gloves, nor did she perform hand hygiene after wiping R323. V7 proceeded to pull R323's brief and pants up with the same dirty gloves. R323 is on enhanced barrier precautions requiring staff to glove and gown up when providing hygiene care as documented on the enhanced barrier sign. V7 did not put a gown on while providing peri-care to R323.</p> <p>The facility's Hand Washing Policy dated 7/1/23 documents, If hands are not visibly soiled, use hand sanitizer: Before moving from contaminated body site to a clean body site during resident care. The facility's Incontinence Care Policy dated 7/1/23 documents, Wash all soiled skin areas and dry very well .changing gloves and performing hand hygiene as required to prevent cross-contamination. The facility's Isolation Equipment and Supplies policy dated 7/1/23 documents, Personal protective equipment (gloves, gowns) are worn when handling or transporting resident-care equipment and supplies that are visibly soiled or have been in contact with blood or body fluids.</p>