STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007439	A. BUILDING: _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ST CHARLES	611 ALLEN LANE ST CHARLES, IL 60174

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #1975638 / IL # 114493	S 000		
S9999	Final Observations Licensure Violations 1 of 2 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was supervised in the shower, and failed to ensure a resident was supervised traveling to and from a colonoscopy appointment in Chicago. This applies to 1 of 11 residents (R1) reviewed for supervision in the sample of 12. The findings include: R1's Face Sheet showed he has diagnoses of left below the knee amputation and legal blindness. R1's July 9, 2019 Minimum Data Set (MDS) showed he is cognitively intact, has no behaviors, and requires physical help from one person for bathing and locomotion off the unit. R1's Falls care plan (revised July 23, 2019) showed he is at high risk for falls or fall related injuries related to decreased mobility, blindness, and amputation. Interventions on the Falls care plan showed "Ensure I will be able to use the call light," and "Please make sure that my call light is within my reach ..." On August 2, 2019 at 8:25 AM, R1 was trying to propel his wheelchair through the hallway to his room, feeling the railings and the walls as he moved. R1 stated he had a colonoscopy scheduled for the morning of July 31, 2019 at a hospital in Chicago as a follow-up to a	S9999		

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colonoscopy he had in May. R1 stated he had drunk all the prep and "messed the bed" during the night, so the night shift CNA (V17-Certified Nursing Assistant) put him in the shower around 5:45 AM, which was 15 minutes before the end of V17's shift. R1 stated V17 left him by himself in the shower room and told him he would tell the next shift. R1 stated staff do not leave him in the shower room, and V17 never showed him where the call light was.

R1 stated he was able to shut the water off in the shower and he had no towels, so he "air-dried." R1 stated he was yelling out, and V6 (CNA) finally heard him and came into the shower room. R1 stated V6 went to get V7 (R1's assigned CNA). R1 stated V7 told him that a hospice employee seeing another resident told her that R1 was not done with his shower. R1 stated he was not aware anyone came in to check on him in the shower.

On August 2, 2019 at 8:25 AM, R1 stated his transportation pick-up time for his colonoscopy was 7:00 AM. R1 stated when he asked for the time when he got out of the shower, he was told it was 12 minutes to 7:00 AM. R1's July 23, 2019 progress note showed family notified the facility then that they would not be available to accompany him to the colonoscopy in Chicago.

On August 2, 2019 at 8:25 AM, R1 stated when he was leaving for his colonoscopy, the transport driver told staff that R1 needed someone to accompany him. R1 stated it was an hour and a half ride to the Chicago hospital. R1 stated when the colonoscopy was over, the transport driver said they were running late so R1 was kept in the prep room at the hospital.

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On August 2, 2019 at 10:10 AM, V6 verified she heard R1 yelling in the shower room so she opened the door to see if he was okay. V6 stated R1 told her no, he was not okay, and he had been waiting in the shower room by himself. V6 stated she got V7 to assist R1.

On August 2, 2019 at 10:20 AM, V7 stated a hospice employee told her around 6:15 AM that R1 was in the shower, and V6 alerted her to R1 yelling in the shower around 6:40 AM. V7 stated R1 told her V17 put him in the shower before he left for the day. V7 stated V17 did not notify her R1 was in the shower. V7 stated R1 "was pretty much dry" when she got in the shower room, and he did not have any towels. V7 stated R1 did not have a call light.
V7 showed the surveyor where R1 was located in the shower room. The shower area was approximately 20 feet in from the hallway, with a short, narrow "hallway" leading to the wall with water on/off knob was. V7 stated usually residents are seated in the shower chair facing out of the narrow area, and R1 was in a shower chair facing the wall. V7 stated R1 could not have reached the call light because it was on the wall on his left and was out of his reach behind the shower chair. V7 stated she did not know if R1 knew where it was. V7 stated when she got to him, R1 was just sitting there with the water off.

On August 2, 2019 at 2:35 PM, V1 RN (Director of Nursing) stated "we don't usually allow residents shower to alone ...we want to make sure they are supervised and it's a safety issue." V1 added "you're not supposed to leave someone in the shower room alone who is blind and cannot reach the call light."

The facility's Appointment and Transportation

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Policy (revised April 19, 2019) showed "4. Depending on a resident's medical, physical and cognitive needs and condition, the resident may require an escort while out of the facility for an appointment. If the resident has no representative, family member, friend, etc. to escort him/her during the appointment, the facility will provide one."

On August 6, 2019 at 1:50 PM, V13 (RN) stated residents should not be left in the shower room alone. V13 stated there is a lock on the outside door so residents do not accidentally end up in there. V13 stated even if a resident is alert and oriented, anybody can get hurt. V13 stated no resident in the facility is independent for showering, and residents should be able to reach the call light.

On August 6, 2019 at 1:50 PM, V13 stated residents that are blind, cannot walk, and are going to a colonoscopy appointment in Chicago would need someone to go with them to the appointment.

On August 8, 2019 at 10:35 AM, V21 (Administrator) stated he could not find an accident prevention or supervision policy. Under the "Acuity" portion of the Facility Assessment (revised June 7, 2019), it showed no residents were independent for bathing.

(B)

Licensure Violations 2 of 2

300.610a)
300.1210b)4)
300.1210d)2)A)B)5)
300.1230 i)

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S9999	Continued From page 5 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living	S9999		

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shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1230 Direct Care Staffing

i) The facility shall schedule nursing personnel so that the nursing needs of all residents are met.

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have sufficient licensed and unlicensed nursing staff to provide cares for Activities of Daily Living (ADLs), provide wound treatments and wound assessments, and failed to respond to equipment alarms in a timely manner.

This applies to 10 of 11 residents (R2-R11) reviewed for staffing in the sample of 12.

The findings include:

1. R3's Face Sheet showed diagnoses of unspecified dementia and an unstageable pressure ulcer of her left heel.
R3's August 2019 Physician's Order Sheet (POS) showed a July 22, 2019 order for her pressure ulcer treatment to be performed daily.

On August 2, 2019 at 10:35 AM, V8 (RN) stated the facility does not have an official wound nurse.

On August 2, 2019 at 10:45 AM, V1 RN (Director of Nursing) stated wound treatments are done by the floor nurses if there is no treatment nurse.

On August 2, 2019 at 1:00 PM, R3 was in a wheelchair at her bedside with a padded blue calf boot on her left leg. V8 assembled supplies to

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perform R3's wound treatments. V8 removed the blue boot, rolled gauze that was present halfway up R3's left leg, and wrapped around the middle of R3's foot. R3's pressure wound on her left heel had a dried alginate pad stuck to it, with a very small area of moist tan drainage on it. The rolled gauze did not cover the alginate, and the rolled gauze was stained with a dried, tan, drainage that covered an area approximately five inches by nine inches on the gauze. A piece of tape held the rolled gauze in place, and the tape was dated July 26 (seven days earlier). R3's heel wound contained an area of unstable eschar.

On August 2, 2019 at 1:50 PM, V8 stated R3's wound treatments are ordered daily, and if they are ordered daily by the physician, they should be completed daily per the order.

R3's wound notes showed her pressure wound was assessed by the wound physician on July 22, 2019, and not assessed again until August 5, 2019 (a 14 day gap).

On August 6, 2019 at 10:45 AM, V1 RN (Director of Nursing) stated pressure ulcers should be assessed at least weekly and the assessment documented. V1 verified R3 had no wound assessment completed for 14 days.

2. R5's Face Sheet showed he was admitted on July 15, 2019 with a diagnosis of a stage 4 pressure ulcer to his sacral region. R5's August 5, 2019 Wound Physician note showed his sacral pressure ulcer has undermining. R5's August POS showed a treatment order to clean the pressure ulcer, apply a debriding ointment, pack with calcium alginate and cover with a dry dressing every day.

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On August 2, 2019 at 11:30 AM, V8 (RN) stated if there is no wound nurse, nurses do their own treatments on their resident assignment. V8 stated when a treatment is completed, nurses sign it off in the computerized Treatment Administration Record (TAR). R5's August 2019 TAR showed his treatment to his pressure ulcer was not signed off on August 1, August 2, or August 3, 2019.

On August 6, 2019 at 12:00 PM, V2 RN (Registered Nurse) prepared to perform R5's treatments. R5 was in bed on his back and multiple areas of redness and scabbing were noted on his left leg. R5 was asked if facility nurses performed his treatments to his wounds every day. R5 replied "they have missed a couple of days."

3. R4's Face Sheet showed he has diagnoses of unspecified dementia and hemiparesis affecting his dominant side. R4's June 21, 2019 Minimum Data Set (MDS) showed staff determined he is severely cognitively impaired, he is always incontinent of bowel and bladder, and he requires extensive assistance of two people for toileting assistance.

On August 2, 2019 at 10:00 AM, R4 was in a reclining wheelchair at a small table in the corner. His eyes were closed, his mouth was open, and a coffee cup was on the table in front of him. R4 had dirty napkins on his chest from breakfast. On August 2, 2019 at 2:40 PM, R4 was still in his wheelchair in the corner. R4 had a towel on his chest with tan debris on it from lunch. A small bowl with a few pieces of pink fruit in it was in front of him on the table.

On August 2, 2019 at 4:10 PM, R4 remained at

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the same place at the table in the corner. A two inch long dark drip of something was dried on his face, having appeared to run from his mouth to his chin. His shirt was wet at the bottom, and he had pieces of pink fruit and bits of carrot stuck to the legs of his sweatpants. R4's lap was wet, between his legs was wet, and the left side of his pant leg was wet.

On August 2, 2019 at 4:15 PM, V6 CNA (Certified Nursing Assistant) was made aware that R4's pants were wet, and she and V19 (CNA) assisted R4 to his room. R4 was assisted to a standing position with a mechanical lift with the help of V6 and V19. R4 was upset, trying to reach and grab at V6 and V19 and he tried to remove the mechanical lift straps. R4's left pant leg was wet all the way to the elastic bottom of his sweatpants, and his incontinence brief was saturated with urine and stool. V6 stated R4 "was [V20's (CNA)] ...This is ridiculous ...I can't do everybody's people." V19 stated "it was like that with everybody [V20] had today."

On August 2, 2019 at 4:35 PM, V1 RN (Registered Nurse, Director of Nursing) stated when residents are wet, staff has to change them. V1 stated "We all follow up on what CNAs do."

On August 6, 2019 at 1:50 PM, V13 (RN) stated "Nurses directly supervise CNAs."

4. R10's Face Sheet showed he has diagnoses of osteoarthritis and morbid obesity. R10's May 20, 2019 MDS showed he is cognitively intact.

On August 6, 2019 at 2:40 PM, R10 was lying in bed in a gown. R10's room is the last one at the end of the hall. A urinal was at the bedside and there were three Styrofoam cups on his bedside

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table. A wall clock was standing on a cardboard box in the corner. R10 stated he takes diuretics around 4:00 AM or 5:00 AM and he "pees for the next six hours." R10 stated he fills his urinal and has nowhere to go with it. R10 uses his call light to have staff empty his urinal. R10 stated staff call light response time has been an hour and ten minutes, an hour and twenty minutes, and an hour and thirty-five minutes. R10 stated he knows how long the call light is on because he can see the clock in the corner. R10 stated when staff do not come, he empties the urinal into the Styrofoam cups and leaves them on his table so he can use the urinal again. R10 stated the long response time has happened in the last four weeks, and he spoke with V1 (RN, Director of Nursing) the day before. R10 stated staffing problems have been going on for a long time.

R10 stated his shower day is Friday, and he missed one recently because there was some discussion if R10 was an AM or PM shift shower. The "Bathing" section in R10's Electronic Medical Record showed he had a shower on July 19, 2019, and no more until after August 2, 2019 (14 days without a shower).

5. On August 6, 2019 at 1:35 PM, R9 was in a wheelchair at a table in the small dining room. In front of him was a lunch plate with peas, Salisbury steak and rice on it. R9 had not eaten any of it and no staff was present.

On August 6, 2019 at 1:45 PM, V11 (RN) walked by and stopped at R9 and asked him if he was still hungry and if he wanted something else. R9 shook his head "yes" and V11 offered him a sandwich. V11 stated she did not know why R9's food was still sitting in front of him and that was why she went to him.

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The facility's General Care policy (revised February 20, 2018) showed "It is the facility's policy to provide care for every resident to meet their needs."

6. R7's Face Sheet showed he has a stage 4 pressure ulcer to his left heel, and his August 2019 Physician Order Sheet showed he has an IV antibiotic every eight hours for it.

On August 6, 2019 at 9:15 AM, R7's was in bed with IV tubing going from an IV pump at the bedside into his right arm. R7's IV pump was alarming. The pump's display was blinked, flashing "air in line."

On August 6, 2019 at 9:45 AM, R7's IV tubing remained connected, and the pump continued alarming.

On August 6, 2019 at 9:55 AM, V2 (Wound RN) was in R7's room preparing to perform his wound treatments. The IV tubing was still connected to R7, and the alarm was still sounding (40 minutes later).

On August 6, 2019 at 1:50 PM, V13 (RN) stated "an IV pump alarming 'air-in-line' should really be attended to in five minutes ...and a GT alarm is the same ..."

7. R2's Face Sheet showed she was admitted in April 2019 and has diagnoses of diabetes and cellulitis of her right leg. R2's July 17, 2019 MDS showed she is cognitively intact and requires physical help of one person for bathing and toilet use.

On August 2, 2019 at 10:50 AM, R2 stated she

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

did not think there was enough staff working at the facility. R2 stated she knows when she has to use the bathroom and she does not want to wet the chair or the floor. R2 stated it happened a lot when she was first admitted, and the last time it happened was around a week ago at 5:00 AM. R2 stated "it took the girl 45 minutes to get here and then she told me 'I'm the only one here!'"

R2 stated she has missed two showers since she was admitted. R2 stated her regular shower day was Tuesday, but all of sudden it could not be done then and nobody told her. R2 stated Saturday came and she was told someone "had an emergency" and it could not be done, then 2:00 PM came and a CNA told her she would be back at 4:00 PM. R2 stated at 5:00 PM, the CNA told her she could not help her because it was suppertime, then 7:00 PM came and R2 was told there was no time. R2 stated "they said I refused it, but I didn't." R2 stated she finally got her shower on Thursday, August 1st (nine days later).

R10 added she did not believe anyone wanted to work the night shift either. R10 stated "At night I hear people screaming and hollering and I just want to get up and help them." R10 stated staff then tell her things like "oh, that's just the way she is."

8. R8's Face Sheet showed he had a traumatic subarachnoid hemorrhage and a gastrostomy tube (GT) for feeding. R8's August 2019 POS showed he should receive 400 milliliters of liquid nutrition over an hour, three times a day.

On August 2, 2019 at 1:00 PM, V8 (RN) assembled supplies to perform R3's wound treatment outside of R3's room. During her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007439	A. BUILDING: _____ B. WING _____	C 08/08/2019

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S9999	Continued From page 14	S9999		

treatment, R3's door was left open. R8's room was across the hall from R3's room and R8's tube feeding pump was alarming across the hall.

On August 2, 2019 at 1:25 PM, V8 left R3's room to obtain more gauze. R8's feeding pump continued to alarm without being addressed by staff.

On August 2, 2019 at 1:43 PM ,V8 finished R3's treatment and answered some questions about R3's treatment.

On August 2, 2019 at 1:50 PM, V8 went into R8's room to check the alarming pump.

9. R6's Face Sheet showed she has diagnoses of dementia and history of falls. R6's July 23, 2019 MDS showed staff determined she was severely cognitively impaired and requires extensive assistance of two people for toileting.

On August 6, 2019 from 9:05-9:20 AM, R6 was in a wheelchair at a table in the small dining room. Her head leaned to the right.

On August 6, 2019 at 9:40 AM, R6 remained in the same place, and her head was leaning over farther.

On August 6, 2019 at 10:10 AM, V14 (R6's visitor) approached her. V14 stated she did R6's laundry. V14 stated she picked up R6's laundry on Friday and returned it on Saturday. V14 stated she picked it up again on Monday and it had five pairs of wet pants in it, and the smell of urine was very strong.

10. On August 6, 2019 at 3:00 PM, R11 was lying in bed with the head of his bed elevated. His

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 15 lunch tray was still in front of him on a table. (B)	S9999		