STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

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S 000	Initial Comments Investigation of complaints: 2291312/IL143646	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240 a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not meet as evidenced by: Based on observation, interview and record review, the facility neglected to follow their policies for neglect, significant change in condition and fall incident. These failures contributed to a resident (R1), experiencing a delay in medical treatment and sustained multiple falls. R1 was hospitalized on 2/12/2022 with altered mental status, new onset of anemia, and a newly diagnosed right lower lobe nodule. This applies to 1 of 3 residents (R1) reviewed for	S9999		

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S9999	Continued From page 2 neglect. The findings include: The EMR (Electronic Medical Record) shows that R1, a 69 year old with diagnoses of current COVID infection, encephalopathy, bipolar disorder, manic episode without psychotic feature, hyperlipidemia, anxiety disorder, mild protein-calorie malnutrition, malignant neoplasm of the breast, schizoaffective disorder, history of falling, Parkinson's disease, muscle wasting, unsteadiness of the feet, gait and mobility abnormality, lack of coordination and cognitive communication deficit. Interviews were held with the staff who were on duty on 2/11/2022-2/12/2022, from 11:00 P.M. through 7:00 A.M. shift and were in charge of R1's care: -V5 (Nurse), was interviewed on 2/19/2022 at 10:13 A.M. V5 said "(R1) did not have a fall when I worked that shift. She was just wandering around, redirected as needed, I let her wander so she can get tired, and when she gets tired, then she will be redirected to bed." V5 said that she did not assess R1 for the wandering behavior. -V7 (CNA/ Certified Nurse Assistant) was interviewed on 2/19/2022 at 7:28 A.M. V7 said that R1 was pacing, wandering all night through and did not sleep at all. V7 also said that R1 cannot be redirected, very agitated, very weak, gait was very unsteady and had fallen at least at minimum of 6 times that night shift. V7 also added that R1 tried to escape the facility by trying to get to the elevator, stairway and the glass window. V7 also said that she saw V5 "just sat at the nursing station and did not stand up at all to check (R1). I am not a nurse, but definitely	S9999		

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S9999	Continued From page 3 something was going on and a huge change for (R1), but (V5) did not check her, she might need medication or just send her out to the hospital since she was very weak, has COVID, very unsteady gait and walking with head leaning down almost hitting wall or counter. She definitely needed something that night. We, together with (V8 and V9) informed (V1, Adminstrator,V2, Director of Nursing and V10, Human Resource that day of 2/12/2022 that (V5) did not do his job as a nurse to check (R1's) needs and felt (V5) had neglected (R1). V7 also added that this was definitely a significant changed of R1's medical and mental status that night shift, she was different from her baseline." -V8 (CNA) was interviewed on 2/19/2022 at 1:54 P.M. V8 said that R1 was trying to elope that night, tried to jump off from the window, escape from the stairways and the elevator. V8 added that all the alarms were on and loud, but V5 was just sitting at the nursing station, and reacted like he just woke up, did not get up and did not say anything how to handle R1. V8 also said that R1 fell at least 10 times that night and that R1 had wandered through residents' rooms even if R1 was positive for COVID. V8 added that V5 "neglected to check (R1) and that R's needed medical attention due to change in physical, mental and behavior status." V8 also said that R1's gait was so unsafe and that R1 had walked that night with gait that was very unsteady, bumping the walls and counters because R1's head and upper torso were on a leaned forward positioned. "She was very weak but cannot be redirected to rest." -V9 (CNA), interviewed on 2/19/2022 at 5:17 P.M., V9 said that "(V5) did not take care of (R1's) needs, did not check her at all, just let her	S9999		

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S9999	Continued From page 4 fall and let her wander around, we tried to take care of her, but just (R1) was unmanageable." -V7, V8, V9 all said "just check the camera what (V5) did that night, all we know is that he just sat down and neglected (R1's) care and needs and he did not check (R1). We informed this situation to (V1, Administrator, V2, Director of Nursing and V10 Human Resource on 2/12/2022." -V6 (Nurse for 2/12/2022 morning shift) was interviewed on 2/19/2022 at 10:58 A.M. V6 said that R1 has significant change in mental and physical condition that started the night shift of 2/11/2022. V6 also said that R1 was bumping the medication carts, cannot be redirected and was very weak. V6 added that she sent R1 to the hospital on 2/12/2022 at 11:00 A.M due to significant change in medical status. V6 added that V5 did not inform her that R1 had multiple falls that night shift. On 2/19/2022 at 3:52 P.M., V1 said that the facility's camera was not functioning, so it did not record what happened that night shift of 2/11-12/2022. V1 also said that V7, V8 and V9 did not report an allegation of neglect for R1. V1 said that all they said was "all childish fight and an allegation of discrimination." V1 also said that their statements (V7, V8 and V9) did not show allegation of neglect but an allegation of discrimination. V1 further said that it is the facility's policy to report allegation of neglect to the administrator immediately and that V7, V8 and V9 have failed to report. On 2/19/2022 at 4:00 P.M., V2 said that it was expected for V5 to have checked and assessed R1 to determine immediate medical treatment when R1 had an acute change of condition on the	S9999		

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S9999	Continued From page 5 night of 2/11-2/12/2022. On 2/18/2022 at 10:45 A.M., R1 was observed lying in bed. R1 was confused and was a poor historian. R1 was observed with large bruise on the left side of face and around the left eye. R1 was also noted with large bruise and swollen left lower leg The nurse's notes dated 2/12/2022 at 7:34 A.M. documented by V5 (Nurse) shows that "(R1) was up all night walking in and out of other residents' room. Refused to go to sleep. Patient is confused. Redirected by staff as needed." Further review of the nurse's notes dated 2/12/2022 at 12:39 P.M., documented by V6 (Nurse) shows that "At about 11:00 am, (R1) continue to be confused and disoriented, wandering to other resident rooms, and resisting redirection. At 11:20 am, (R1's Attending Physician) was notified of resident behavior and ordered to send resident to hospital." R1 was admitted to the hospital with diagnosis of "fall and COVID positive." The Medical Provider Notes dated 2/12/2022 shows, "(R1) was sent to the hospital on 2/12/22 s/p (status post) fall and AMS (Altered Mental Status Status). Labs in ED (Emergency Department) showed new anemia and +COVID-19. ...CT (Computerized Tomography) of the chest and A/P (anterior/posterior) showed (R) lower lobe nodule with recommendations to have a CT chest f/u in 3 months. Patient was evaluated by psychiatrist and determined that patient is on the optimal medication regimen for her bipolar disorder overlying Parkinson's disease. ...Patient will need 24/7 supervision and assistance for her	S9999		

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S9999	Continued From page 6 safety and ADLs (Activities of Daily Living). Patient seen and examined in room....Patient noted to have a bruise underneath (R) eye. Patient also noted to have edema and bruise to RLE (right lower extremities). PMH (past medical history of HLD (hyperlipidemia), breast cancer, bipolar disorder, and Parkinson's disease presented to hospital on 1/23/22 with multiple falls, abnormal gait, and illogical speech." The facility's policy for abuse/neglect with a revision date of 1/17/2022 shows that the facility should " provide professional care and services in a manner that is free from any type of abuse... including neglect. Type of abuse: ...Neglect-failure to provide necessary care adequate care (medical and psychological). Neglect is the failure to care for a person in a manner which would avoid him/her pain, or the failure to react to a situation which may be harmful. Staff maybe aware of should have been of the situation that resident require but fails to provide that care and service. ... All allegations of abuse or suspicions of abuse/neglect should be reported to the administrator immediately." The facility's policy for significant change in medical status dated 7/28/2021 shows to provide care immediately to residents who were noted with significant change in medical condition. The facility's policy for fall with a revision date of 7/28/2021 shows that facility should "ensure that residents are assessed for risk for falls and interventions are put in place...4. An incident report will be completed by the nurse each time a resident fall. 5. The nurse initiate and start interventions to address falls in the unit."	S9999		

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