STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000756	A. BUILDING: _____ B. WING _____	09/13/2024

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GROVE HEALTH & REHAB CTR, THE	873 GROVE STREET JACKSONVILLE, IL 62650

(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 Annual Licensure Certification & Complaint Survey: 2447007/IL1777503	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.1210b) 300.1210d)6 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by:	S9999		

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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.

Findings include:

R12's Admission Record, print date of 9/11/24, documents that R12 was admitted on 1/20/24 with diagnoses of Repeated Falls, Mild Cognitive Impairment, and Pallative Care.

R12's Minimum Data Set, dated 1/24/24, 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.

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."

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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."

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."

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."

R12's Cervical Spine 2 views, dated 4/9/24,

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documents, "Impression: Interval improved anatomic alignment of the anterior superior corner fracture fragment of C5 vertebral body since prior CT (computed tomography scan) study."

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."

R12's Health Status Note, dated 6/18/24, documents, "orders received per hospice to d\c (discontinue) neck brace."

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.

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 onto them. These 4 oxygen cylinders also are not secured to prevent being knocked over and causing injury.

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."

On 9/10/24 at 10:30 AM, V2 , Director of Nurses, (DON), was questioned about the oxygen tanks in

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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."

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."

R12's Health Status Note, dated 9/9/24, documents, "IDT (intradisciplanary 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
Care plan updated."

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."

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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 ischemial 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."

The policy Accidents & 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."

(A)

Statement of Licensure Violation 2 of 3

300.1210b)
300.1210d)3

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.

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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.

These Requirments were NOT MET as evidenced by:

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.

Findings include:

R323 was admitted to the facility on 7/3/2024 with diagnosis of, in part, fracture of unspecified part of neck of left femur, unspecified fall, unspecified dementia.

R323's MDS dated 8/12/24 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.

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)

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with an intervention for eating to provide set-up and assist as needed.

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.

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.

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.

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

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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.

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."

(B)

Statement of Licensure Violations 3 of 3

300.1210b)
300.1210d)1

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These Requirments were NOT MET as evidenced by:

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.

Findings include:

R223 was admitted on 2/28/24 with diagnoses of metabolic encephalopathy, convulsions, schizophrenia.

R223 Minimum Data Set, MDS, dated 7/25/24, documents that R223 is cognitively intact.

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)."

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

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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."

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"

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"

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,"

R223's Health Status Note, dated 8/11/2024 09:35 AM, documents, "Resident in the Dining room eating breakfast staff noted resident seizuring (sic) writer went to resident to observe and give support seizure lasted about 2 minutes

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.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"

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)

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"

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"

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 (Springfield)."

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
-Start Date07/20/2024 0600 -D/C Date07/28/2024 0942."

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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."

R223's MAR, documents, "OXcarbazepine Oral Tablet 300 MG (Oxcarbazepine) Give 300 mg orally two times a day related to EPILEPSY, UNSPECIFIED, NOT 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."

R223's Hospital Record, signed date of 8/12/24, documents, "Assessment ? Plan (R223) is a 69 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)."

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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000756	A. BUILDING: _____ B. WING _____	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE HEALTH & REHAB CTR, THE	873 GROVE STREET JACKSONVILLE, IL 62650

(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 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." 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." 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. (A)	S9999		