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| S 000 | Initial Comments<br><br>Licensure First Probationary (L/P1) due to Change of Ownership | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.1620a)<br>300.2040b)<br>300.2090a)b)<br>300.2210b)1)3)9)<br>300.2930c)4)<br>300.3220f)<br>300.696a)<br>300.1210d)4)<br><br>Section 300.1620 Compliance with Licensed Prescriber's Orders<br><br>a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.<br><br>This requirement is not met as evidenced by:<br><br>Based on observation, record review and interview the facility failed to administer medications as ordered by the physician. There were thirty opportunities with four errors This applies to 1 of 2 residents (R36) reviewed | S9999 | Attachment A<br>Statement of Licensure Violations | |

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during medication pass.
The Findings Include:
According to R36's current face sheet, R36 was admitted to the facility on September 9th 2015 with diagnoses that included Major Depressive Disorder, anxiety disorder and seizures.
R36's current physician order shows that R36 had multiple medications ordered for 9:00am which included Zinc Sulfate 220mg two tablets by mouth daily, Captopril 12.5mg by mouth two times a day, Sertraline HCL 100mg two tablets by mouth daily, and Primidone 50mg two tablets by mouth daily,
On February 17, 2016 at 9:30am, E11 (Nurse) administered multiple medications to R36, which included Zinc Sulfate 220mg one tablet by mouth instead of two tablets; Captopril 12.5mg by mouth two tablets by mouth, instead of one tablet; Sertraline HCL 100mg one tablet by mouth, instead of two tablets; and Primidone 50mg one tablet by mouth instead of two tablets.
On February 18th 2016 at 2:20pm, E2 DON (Director of Nursing) stated the nurses are expected to administer the right dose of all medication as ordered by the physician.

(B)

Section 300.2040 Diet Orders
b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.
This requirement is not met as evidenced by:

Based on observation, interview and record review the facility failed to serve resident diets as ordered by the physician.

This applies to 2 of 2 residents (R2, R3) reviewed for therapeutic diets in the sample of 9.

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The Findings Include:

On February 16, 2016 at 12:38 pm, R2 was seated in the dining room with his tray in front of him. His food was served on a 3 compartment plate and with two bowls of pureed items identified as split pea soup and peach cobbler. R2 rapidly poured the 2 bowls of liquid foods into his mouth as the contents spilled onto his shirt and lap. Z1 (private sitter) used several napkin to try to contain and remove the spillage.

R2 diagnoses include Dysphasia and Barrett's Esophagus according to the Physician Order Sheet of January 5, 2016. Diet order is regular diet, pureed texture and honey consistency.

R2's Dysphasia Evaluation dated January 4, 2016 shows his diet as puree with honey thick liquid due to a history of aspiration.

R2's care plan initiated January 11, 2016 shows staff is to provide diet at the consistency ordered by the physician.

R2's Medication Administration Record dated February 1 - 29, 2016 shows Diet order as regular diet, pureed texture and honey textured.

R2's Care plan initiated January 11, 2016, shows staff is to observe resident R2 will tolerate puree meal with honey thick liquid.

2. R3 was admitted to the facility with diagnoses that included hemiplegia and Hemiparesis following other cerebrovascular disease affecting right dominant side, vascular Dementia, Aphasia and generalize muscle weakness according to R3's face sheet.
R3's MDS (Minimum Data Set) showed R3's

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cognition cannot be assessed and R3 was totally dependent on staff for personal hygiene.
On February 17th 2016 at 11:30am, R3 was sitting in her wheel chair on the right side of her bed. R3's tube feeding bag was hanging on the pole with about 200ccs feeding in it. R3's Tube feeding was not infusing.
On February 17th 2016 at 1:50pm, R3 was sitting in her wheelchair on the right side of her bed. R3's tube feeding bag was hanging on the pole with about 200ccs feeding in it. R3's tube feeding was not infusing. On February 17th 2016 at 2:00pm, E10 (Nurse) stated he was the nurse for R3 this morning. E10 stated R3 is to have tube feeding infusing continuously. E10 stated R3's feeding started at 6:00pm on February 16, 2016 and will be stopped at 2:00pm on February 17th 2016 according to R3's physician's orders. E10 stated he was going to disconnect R3's feeding at 2:00pm.
On February 17th 2016 at 2:03pm E9 CNA (Certified Nursing Assistant) stated he disconnected R3's feeding at 10:00am when he assisted R3 up to the wheelchair and the nurse was supposed to reconnect R3's feeding. E9 stated he just came in R3's room and assisted R3 back to bed. E9 stated R3's feeding was not connected at 2:00pm.
On February 18th 2016 at 11:35pm, E2 DON (Director of Nursing) stated the CNAs are not allowed to disconnect the tube feeding.

Section 300.2090 Food Preparation and Service
a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use.
b) Foods shall be attractively served at the proper

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temperatures and in a form to meet individual needs.
This requirement is not met as evidenced by:

Based on observation, interview and record review the facility failed to prepare foods according to menu and in the correct consistency form.

This applies to 2 of 2 (R2, R6) reviewed for pureed diets in the sample of 9 and 13 (R24-35) residents in the supplemental sample.
The Findings Include:
On February 16, 2016 during tour of kitchen at 10:15 am with E3 (dietary manager), E4 (cook) stated she had prepared turkey pot pie according to the recipe. E4 was asked to read the recipe aloud and explain what the recipe required the cook to do. E4 was unable to read and explain wording in the recipe such as: (thaw, shred, roux) to either the surveyor or E3.
On February 17, 2016 at 1:15pm a pureed diet test tray was provided and tested. E3 witnessed the pureed green peas to contain shreds of the peas outer skin and required additional chewing before swallowing; cauliflower and bread both had standing liquid of which E3 stated as being 'too watery'; and the parmesan crusted fish had visible chunks which required additional chewing before swallowing of which E3 stated it was not the correct consistency
Policy titled Pureed/Dysphagia dated 2010 shows the following:
Pureed/dysphagia diets will be served as ordered by the physician
Whole food will be pureed in a blender or a food processor to a semi-solid consistency (i.e. the consistency of "pudding-like"
Standardized recipes for pureed food will be followed

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Policy titled Diet Standardization dated 2010 shows the following:
Meats, vegetables, starches and fruits will be pureed to a semi-solid consistency "pudding-like" consistency.

(C)

Section 300.2210 Maintenance
b) Each facility shall:
1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards.
3) Maintain all electrical cords and appliances in a safe and functioning condition.
9) Maintain all plumbing fixtures and piping in good repair and properly functioning
This requirement is not met as evidenced by:
Based on observation and interview, the facility failed to maintain tiles, handrails, electrical cords and plumbing in safe and working manner.
This applies to 9 of 9 residents (R1-R9) residents reviewed for ADL (activities of daily living) assistance, including showers, and 14 residents (R10-23) in the supplemental sample.
The Findings Include:
During initial tour of the facility on February 16, 2016 at 10:28 AM in R10's room, exposed wires were hanging from the wall between R10's bed and night stand.
During Environmental Tour of the facility on February 17, 2016 between 10:00 AM and 11:40 AM with E3 (Environmental Manager) and E1 (Administrator), exposed wires were again observed hanging from the wall in R10's room.
The handrail outside R18's room was very loose and hanging away from the wall so that at least 1" of space existed between the bracket and the

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wall. E3 said, "The painters must have forgotten to tighten the handrail down after painting the wall."
Cracked tiles were observed in all three shower rooms; south, central and north shower rooms. These showers are used by all 9 residents (R1 to R9) in the sample. The hot water faucet on the sink in the North Shower Room was not fastened to the sink and continuously spun around when attempting to turn on/off the hot water.
The water faucet in R11 and R23's restroom was leaking copious amounts of water when the faucet was turned on. R23 said the faucet leaks all the time. White sediment was caked on the faucet in the areas where the water leaked when the faucet was turned on.
On the lower level of the facility at 11:15 AM, E6 (Maintenance) went into and out of the Boiler Room. E6 unlocked the door for E3 and we entered the room. Water was running down from pipes onto blankets on the floor. The blankets were soaked through and were being used to soak up the dripping water. E3 identified the water as "sewage, from the toilets upstairs." E6 said, "No one has been here to try to fix this yet, I reported it two days ago using email to my Maintenance Director, but he is on vacation."
Inside the boiler room, two electric wheelchairs and a barbecue grill were being stored. Water was also on the floor, dampening the bottoms of our shoes as we walked out into the hallway shared by the Physical Therapy and Restorative Departments. E3 said the hallway outside the boiler room is used by the Physical Therapy Department and Restorative Department to ambulate residents. On February 18, 2016 at 10:30 AM, Z2 (Rehab Manager) said R12-R18 ambulated in the hallway outside the Boiler Room on February 17, 2016. "R12 wears non-skid socks because she ambulates short distances at

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a time, and R13 and R17 wear house slippers when they ambulate." The facility provided a list of residents who received restorative ambulation in the same hallway shared by the Boiler Room on February 17, 2016. Those residents included R19-R23.

Section 300.2930 Plumbing Systems
c) Water Supply Systems
4) Hot water distribution systems shall be arranged to provide hot water of at least 100 degrees Fahrenheit at each hot water outlet at all times

This requirement is not met as evidenced by:
Based on observation and interview, the facility failed to ensure hot water temperatures were comfortable for residents during handwashing and showering.
This failure has the potential to affect all 126 residents in the facility.

The Findings include:

During Environmental Tour of the facility on February 17, 2016 between 10:00 AM and 11:40 AM with E3 (Environmental Manager) and E1 (Administrator), water temperatures were checked in the shower rooms and in resident's rooms. E1 checked water temperatures in the shower rooms. Water temperatures in the shower rooms ranged between 80.0 and 85.7 degrees. While checking the water temperatures, E1 did not acknowledge he was aware of any problems with the hot water temperatures in the facility.

The water faucet in R11 and R23's restroom was leaking copious amounts of water when the faucet was turned on. R23 said the faucet leaks

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all the time. The water temperature from the faucet was 95 degrees. R11 said, "Our showers are cold most of the time. When I asked why the water is so cold, the staff told me it's the best they can do."

E3 (Environmental Manager) said she was not aware there was a problem with the hot water in the facility.

The facility's document titled "Resident Roster" shows a census of 126 residents.

(C)

Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)
This requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure physician's orders were followed for a resident with a PICC (peripherally inserted central catheter) line. This applies to 1 of 3 residents (R5) reviewed for specialty care in the sample of 9.
The Findings include:
During initial tour of the facility on February 16, 2016 at 10:15 AM with E7 (ADON-Assistant Director of Nursing), R5 was sitting in his room on the edge of his bed. E7 identified R5 as an incontinent resident on contact precaution isolation for ESBL (Extended spectrum beta-lactamase) of the urine. R5 was wearing a short-sleeved shirt, and his right upper arm was exposed. An undated, transparent dressing was

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covering a gauze dressing over the insertion site of R5's PICC line in R5's right upper arm. E7 could not say when the dressing was changed last. The transparent dressing was curling at the edges. The insertion site of the PICC line could not be visualized or assessed due to the gauze covering the insertion site.
The facility's EMR (electronic medical record) shows R5 was admitted to the facility on February 3, 2016 with a PICC line in place.
The facility's POS (Physician Order Sheet) dated February 1 to February 29, 2016 shows the following orders dated February 3, 2016: "Change IV catheter dressing and cap with transparent dressing every day shift every Sunday, Measure PICC line external length catheter one time a day every Sunday, and Measure (specify) upper arm midcircumference every day shift every Sunday."
The facility lacked any documentation to show what the external catheter length and arm circumference was on Sunday February 7 and February 14, 2016, when the dressing change was done.
E2's (DON) Vascular Access Evaluation dated February 3, 2016 showed an external catheter length of 11 cm. (centimeters) and an arm circumference of 25 cm. on admission. On February 17, 2016 at 10:30 AM, E2 said the only measurements taken for R5's PICC line were done by her on admission. "It's not our policy to measure the PICC line unless we can see it has migrated out, but if the nurse did it, she should have documented that in the nursing progress notes."
The facility's "Intravenous Policy and Procedure" dated July 30, 2014 shows: "Policy: It is the facility's policy to ensure that intravenous policy and procedure are compliant to federal standard of care. Procedure: 1) All IV access will be assessed by the nurse to ensure that no signs

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and symptoms of infection and infiltration are left unaddressed. 2) Dressing change: b) All central line dressing (PICC lines, single and multi-lumen central catheters inserted in subclavian, jugular or inguinal area) will be changed every 7 days and prn. ..A transparent sterile dressing will be applied over the central line catheter insertion site. The outside of the dressing will then be labeled with dressing change date and time. Additionally for PICC line, the length of the external catheter and arm circumference may be measured to monitor movement ..."
The Infusion Nursing Standards of Practice dated January/February 2011 states " The Nurse should measure the external CVAD (central vascular Access Device) length and compare to the external CVAD length documented at insertion. Dislodgment could indicate the tip location is suboptimal, increasing the risk for catheter-related thrombosis. "

Section 300.696 Infection Control
a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.
This requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow their infection control policy for a resident in contact isolation.
The Findings include:
This applies to 1 of 1 residents (R5) reviewed for isolation in the sample of 9.

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During initial tour of the facility on February 16, 2016 at 10:15 AM with E7 (ADON-Assistant Director of Nursing), R5 was sitting in his room on the edge of his bed. E7 identified R5 as an incontinent resident on contact precaution isolation for ESBL (Extended spectrum beta-lactamase) of the urine. R5 was wearing a short-sleeved shirt, and an incontinence brief. R5 was not wearing any pants. A urinal was sitting on the floor between R5's legs. E8 (CNA-Certified Nursing Assistant) was in R5's room. E8 said R5 uses the urinal sometimes. E8 was not wearing any PPE (personal protective equipment). E8 said, "I don't need to wear a gown, I'm just going in and picking up resident's breakfast trays. E8 had R5's breakfast tray in his hands and walked out of the room with the tray. E7 (ADON) said anyone entering R5's room should wear a disposable gown and gloves. The cart outside R5's room had disposable gowns and masks, but no disposable gloves available. E7 obtained gloves prior to entering the room. The sink in R5's bathroom was not accessible to wash hands prior to leaving the room. A large bath towel hung from inside of the sink down to the floor.

The facility's undated "Infection Control Program Policy and Procedure" shows: "Procedure: ...5) A transmission-based precaution set up will be provided outside the resident's room to provide PPE (personal protective equipment) like gown and gloves to staff and visitors entering the resident's room. ...13) Handwashing for 15 to 20 seconds will be required for all staff after direct patient contact and after each situation that necessitates handwashing. Precautions to Prevent Transmission of Infectious Agents and Transmission Based Precaution: ...2) Contact Precaution - intended to prevent transmission of infectious agents spread by direct or indirect

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| | IL6003412 | A. BUILDING: _____ B. WING _____ | 02/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF NORTHBROOK,THE | 263 SKOKIE BOULEVARD NORTHBROOK, IL 60062 |

| (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 12 | S9999 | | |

contact with patient or the environment. ...b) Use of gown and gloves is necessary for all interactions."

(B)

Section 300.1210 General Requirements for Nursing and Personal Care
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:
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.
This requirement is not met as evidenced by:
Based on observation and interview, the facility failed to provided grooming assistance to residents requiring ADL (activities of daily living) assistance.
This applies to 2 of 9 residents (R3, R7) reviewed for ADL assistance in the sample of 9, and 2 residents (R24, R31) in the supplemental sample.
On February 16, 2016 at 10:50 AM, R3 was sitting in her room. R3 had a large amount of facial hair, including long chin hairs. The facility lacks a care plan for R3's ADL assistance. The facility's MDS (Minimum Data Set) dated February 10, 2016 shows R3 is totally dependent on staff for hygiene.
On February 16, 2016 between 12:15 PM and 1:00 PM, R7, R24, R31 and E12 (CNA-Certified Nursing Assistant) were observed in the small dining room. E12 identified R7, R24 and R31 as needing total assistance with ADL's.
R7 was non-verbal, had contracted hands, and had long, jagged fingernails. R24 was sitting in

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|---|---|---|---|---|
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the chair waiting to be fed a pureed lunch meal. R24's fingernails appeared long with a brown substance underneath. R31 had long facial whiskers and her fingernails appeared long with a brown substance underneath.
On February 17, 2016 at 10:30 AM, E2 (DON-Director of Nursing) said it is the CNAs (certified nursing assistants) responsibility to provide grooming assistance to residents.
(C)