STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

(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 and Certification Complaint Investigation: 2472536/IL171412	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3)5) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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. As a result of these failures, R41 had an unidentified right ischium wound with 25% necrotic tissue that was uncovered with no	S9999		

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GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 2	S9999		

treatment; R24 had a right ischium wound with necrotic muscle tissue exposed with no treatment; and R18 had a right ischium wound with no treatment that increased in size from previous assessments.

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.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify, report, assess, and obtain physician orders for new skin breakdown; failed to ensure treatment dressings were in place, soiled dressings were changed for residents with stage 3 and stage 4 pressure ulcers; and failed to implement pressure ulcer interventions.

This applies to 5 of 5 residents (R9, R18, R24, R41, and R66) reviewed for pressure ulcers in a sample of 30.

The findings include:

1. The EMR (Electronic Medical Record) showed R41 admitted to the facility on 10/20/2023 with multiple diagnoses including multiple pressure ulcer stage, diabetes type 2, nutritional deficit, and tracheostomy dependent on a respiratory

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

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S9999	Continued From page 3	S9999		

ventilator. The MDS (Minimum Data Set) dated 3/19/2024 showed R41 was cognitively impaired and was dependent on facility staff for ADLs (activities of daily living). The MDS continued to show R41 was at risk for developing pressure ulcers because R41 had multiple unhealed stage 3 and unstageable pressure ulcers.

On 4/02/2024 at 10:21 AM, R41 was in bed. V11 (Wound Care Nurse/WCN) and V27 (Certified Nurse Assistant/CNA) turned R41 to perform wound care. R41 was soiled with stool and his left ischium dressing was saturated with yellow drainage and had an open wound to his right ischium without a treatment dressing in place. V11 stated R41's left ischium dressing was soiled from the wound drainage. V11 cleaned the stool off the right ischium wound and said it was her first time seeing the wound, V11 stated the wound had 25% necrotic tissue and the rest was granulation tissue and it appeared like a stage 3 pressure ulcer. V11 continued to remove the soiled dressing then cleansed the wound and applied new treatment dressings to R41's wounds. V11 continued to say she needed to have the Wound NP (Nurse Practitioner) assess the new wound before staging it. Then R41's left corner bed sheet had blood stains and the surveyor asked V11 to assess R41's left foot. R41's left heel was covered with a white island dressing dated 4/03/2024. V11 stated she had never seen the wound before, and she removed the dressing and said it had a medihoney dressing covering the wound bed. V11 then cleaned the wound and it started to bleed, V11 stated the wound bed had 100% slough tissue. V11 stated she had to ask the Wound NP to also assess and measure R41's new left heel wound.

R41's Order Review Report dated 4/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 4	S9999		

showed an order for "Left Ischium-Cleanse area with normal saline, apply collagen and calcium alginate and cover with dry dressing as needed and every day shift for treatment; and Right lateral lower leg: Cleanse with NSS, apply skin prep, and leave open to air as needed AND every day shift every Tue, Thu, Sun for Skin Alteration." The order report did not show a treatment order for the left heel and right ischium.

R41's Skin and Wound Note from the NP dated 4/02/2024 showed R41's left ischium stage 3 pressure ulcer measured 4.2cm x 3cm x 0.5cm with undermining from 11-1 o'clock measuring 1cm with a heavy amount of serosanguineous exudate and right lateral lower leg stage 3 pressure ulcer measured 1cm x 0.5cm x 0.1cm.

R41's Skin and Wound Note from the NP dated 4/04/2024 showed R41 had a facility-acquired right ischium stage 3 pressure that reopened measuring 2.5cm x 1cm x 0.1cm and a new diabetic foot ulcer with partial thickness skin loss measuring 1cm x 1.8cm x 0.1cm with scant amount of serosanguineous exudate.

On 4/05/2024 at 11:17 AM, V11 (WCN) stated the Wound NP assessed R41's new wounds, V11 continued to say R41's right ischium was a reopened stage 3 pressure ulcer, and the left heel was classified as a diabetic ulcer. V11 stated they could not determine the etiology of R41's left heel wound, and they looked at R41's diagnoses to help them classify the wound and made an educated guess. V11 said she was not able to find out who applied a dressing to R41's left heel wound or when it was identified. V11 stated when a new skin alteration is identified nurses should assess it, report to the Wound NP or primary physician to get treatment orders, update the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 5 family, and document it in the chart. 2. The EMR showed R24 admitted to the facility on 2/02/2024 with multiple diagnoses including pressure ulcers stage 4, multiple sclerosis, tracheostomy dependent on respiratory ventilator, muscle wasting and atrophy, and malnutrition. The MDS dated 2/05/2024 showed R24 was cognitively impaired and was dependent on facility staff for ADLs. The MDS continued to show R24 was at risk for developing pressure ulcers because R24 had two unhealed stage 4 pressure ulcers present on admission. On 4/02/2024 at 10:50 AM, R24 was in bed. V11 (WCN) and V27 (CNA) turned R24 to perform wound care. R24's sacrum and left ischium dressings had a foul odor and were saturated, the drainage seeped into the incontinence pad underneath. R24's right ischium was observed without a treatment dressing in place and had necrotic muscle tissue exposed. V11 removed the soiled dressings then cleansed the wounds and applied new treatment dressings. V11 said R24's wounds should have been covered and if the dressing were soiled, they should have been changed. V11 said she expected the floor nurses to cover the wounds as ordered because the wounds could deteriorate. R24's Care Plan dated 4/04/2024 showed R24 had actual impaired skin integrity to his sacrum a stage 4 pressure ulcer, left ischium stage 4 pressure ulcer, and right ischium unstageable initiated on 2/09/2024. R24's Order Review Report dated 4/04/2024 showed an order for "Medihoney Ca Alginate 4"x5" External Pad Apply to left ischium topically as needed for treatment. Apply to left ischium	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6 topically every day shift for treatment. Cleanse wound with normal saline, apply medihoney + calcium alginate and cover with dry dressing; Right ischium: Cleanse with NSS, apply Medihoney, and cover with bordered gauze as needed and every day shift every Tues, Thu, Sun for Skin Alteration; and Sacrum: Cleanse with NSS, apply hydrogel and silver alginate, and cover with bordered foam as needed for Skin Alteration and every day shift for Skin Alteration." R24's Skin and Wound Note from the NP dated 4/02/2024 showed R24's sacrum stage 4 pressure ulcer measured 12cm x 17cm x 1.5cm with undermining from 10-11 o'clock measured at 1.8 cm and with fragile peri-wound and heavy amount of serosanguineous exudate, left ischium stage 4 pressure ulcer measured 5.4cm x 4cm x 2.3cm with tunneling at 12 o'clock measured at 5.3cm and with a moderate amount of serosanguineous exudate, and right ischium stage 4 pressure ulcer measured 6.2cm x 6cm x 0.8cm with exposed tendon/ligament and a moderate amount of serosanguineous exudate. R24's initial Skin and Wound Note from the NP dated 2/13/2024 showed R24's sacrum stage 4 pressure ulcer measured 7.5cm x 7.5cm x 1cm with no undermining with a moderate amount of serosanguineous exudate and left ischium stage 4 pressure ulcer measured 6.5cm x 3cm x 1cm with no tunneling and with a moderate amount of serosanguineous exudate. The note did not show any assessment for R24's right ischium stage 4. R24's Skin and Wound Note from the NP dated 2/15/2024 showed R24's had a new right ischium wound classified as MASD (Moisture Associated Skin Damage) measuring 0cm x 0cm x 0cm with	S9999		

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 7 a scant amount of serosanguineous exudate. On 4/05/2024 at 11:17 AM, V11 (WCN) stated R24's right ischium stage 4 pressure wound was acquired a few months ago as a DTI (deep tissue injury) and then progressed as an unstageable. V11 said the initial assessment was done by the Wound NP, she believes it was found during their wound rounds. 3. The EMR showed R18 admitted to the facility on 3/05/2020 with multiple diagnoses including pressure ulcer stage 4, quadriplegia, tracheostomy dependent on respiratory ventilator, and malnutrition. R18's MDS dated 2/01/2024 showed R18 was cognitively intact and was dependent on facility staff for ADLs. The MDS continued to show R18 was at risk for developing pressure ulcers because R18 had an unhealed facility-acquired stage 4 pressure ulcer. On 4/02/2024 at 10:04 AM, R18 was in bed. V11 (Wound Care Nurse/WCN) and V27 (Certified Nurse Assistant/CNA) turned R18 to perform wound care. R18's right ischium pressure ulcer was observed without a treatment dressing in place and was soiled with stool. V11 cleaned the stool off the wound and said there should have been a dressing covering the wound as ordered. R18's Order Review Report dated 4/04/2024 showed an order for "Right ischium: Cleanse with NSS, apply collagen, and secure with border gauze as needed for Skin Alteration and every day shift every Tues, Thu, Sat for Skin alteration." R18's Skin and Wound Note from the NP dated 4/02/2024 showed R18's right ischium stage 4 pressure ulcer measured 4.5 cm x 4 cm x 0.1 cm. R18's initial Skin and Wound Note from the NP	S9999		

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

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GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 8 dated 7/25/2023 showed R18's right posterior upper thigh (right ischium area) had a partial thickness wound measuring 3 cm x 0.8 cm x 0.01cm classified as a skin tear/laceration. R18's TAR (Treatment Administration Record) for April 2024 showed R18 received wound care to her right ischium pressure wound once on 2/02/2024 by V11. On 4/04/2024 at 11:41 AM, V2 (Director of Nursing/DON) stated she expected the nurses to change dressings when needed and not wait for the WCN. V2 stated each floor had wound care supplies if needed. V2 stated the Wound NP is the one measuring and assessing the facility wounds and notifies her of any changes when she rounds at the facility. 4. On 4/2/2024 at 10:03 AM, while V6 (CNA-Certified Nurse Assistant) and V7 (CNA) were providing incontinence care to R9, it was noted that R9 did not have any wound dressing on her sacral wound. V6 stated it was the first time during her shift (7 AM to 3 PM) that she was providing incontinence care to R9. V6 said it was reported that R9 was last changed around 6 AM. After incontinence care was done, V6 applied incontinent briefs and said she will inform the nurse and the wound care nurse that R9 needed new wound dressing. On 4/2/2024 at 11:54 AM, skin check was done with V6. R9 still had no wound dressing on her stage four pressure ulcer on her sacrum. On 4/2/2024 at 1:06 PM, V11 (Wound Care Nurse) stated she has not been to the third floor to do wound dressings. V11 denied being informed that R9 had no wound dressing for the entire morning. V11 stated R9 had a stage 4 on	S9999		

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 9	S9999		

her sacrum. V11 stated there should always be a wound dressing to prevent the wound from being exposed to urine and feces. V11 stated the dressing also is needed for wound healing. V11 said if there is no wound dressing, the wound has potential for infection and the wound may become worse.

On 4/3/2024 at 9:05 AM, R9's back and buttocks were soaked with fluid coming out from her feeding tube machine. V6 CNA stated V13 (RN-Registered Nurse) informed her at 9:00 AM that R9 needed to be changed because she was soaked. While V6 and V12 (CNA) were providing care, R9's wound dressing on her sacrum was peeled off due to moisture. The wound appeared macerated with wound edges appearing whitish from being soaked in fluid.

On 4/3/2024 at 9:06 AM, V13 stated she did not touch R9's feeding tube. V13 stated the last time the feeding tube was touched was when R9 received her medications around anywhere from 5:00 AM to 7:00 AM. She said fluid seeped out because the valve was not properly clamped. She said she discovered R9 was soaked and informed V6 right away.

On 4/3/2024 at 10:37 AM, V13 measured R9's sacral wound. Measurement was 3.8 cm (centimeters) width x 4.9 cm length x 0.3 cm depth. She said the wound edges appeared macerated and fragile.

R9's face sheet documents she was admitted to facility on 10/3/2022. Diagnoses include hemiplegia, hemiparesis, Alzheimer's disease, aphasia, and dysphagia. R9's MDS (Minimum Data Sheet) documents R9 has severely impaired cognitive functions and is dependent on staff for

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 10 ADLs (Activities of Daily Living). R9's POS (Physician Order Sheet) dated 3/8/2024 has an order to cleanse sacral wound with normal saline, apply xerofoam, and cover with dry dressing every day shift every Tuesday, Thursday, Saturday and as needed. R9's care plan dated 1/3/2024 shows wound care plan has interventions to follow facility protocols for treatment of injury and to keep skin clean and dry. R9's wound assessment done on 3/28/2024 shows sacral wound measured 4 cm width x 4 cm length x 0.10 cm depth. 5. On 4/3/2024 at 10:07 AM, V11, Wound Care Nurse did a skin check on R66. V11 stated R66 had no open areas and skin is being protected with moisture barrier. When R66's incontinence briefs were removed, she turned R66 to her left side, open wounds were noted on her left and right buttocks. V11 did not assess the wounds and did not measure the wounds. V11 applied hydrocolloid dressing to wounds on left buttock and right buttock. V1 said Wound Nurse Practitioner will be in the facility tomorrow. R66's face sheet documents she was admitted to facility on 10/12/2022. Diagnoses includes thoracic, thoracolumbar, and lumbosacral intervertebral disc order, hypertension, dementia, and type II diabetes mellitus. R66's MDS documents she has intact cognitive functions, is always incontinent of bowel and bladder and needs extensive assist from staff for turning and repositioning in bed. R66's Wound Assessment Report dated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 11	S9999		

3/28/2024 documents wound on right buttock and sacrum were resolved.

R66's POS shows there was no treatment order received for her wounds on left and right buttocks on 4/3/2024 when the wounds were discovered.

Review of R66's Progress Notes show no notes were recorded on 4/3/2024 regarding the wounds discovered on R66's right and left buttocks and informing physician of the new wounds.

Last skin evaluation on R66 was done on 3/22/2024.

On 4/4/2023 at 10:52 AM, V15 (Wound Nurse Practitioner) stated resident should not be sitting in moisture like urine or feces or fluid from feeding tubes because there is a potential that resident will develop pressure ulcers or resident's pressure ulcer will deteriorate. V15 stated sitting in moisture could also cause infection and can make wound healing take longer. V15 stated if a resident's wound dressing is not applied, there is a potential for infection and potential for deterioration of the wound. V15 stated R9's sacral wound decline could be in part caused by not applying wound dressing and being soaked in liquid from the feeding tube. She said if wounds were discovered, she expects the nurses to assess the wound, measure the wound, document findings, and inform her about it.

Facility Policy on Wound Care Guidelines dated 12/1/2015 and revised on 1/24/2024 stated the following: ..."3. Prevention of skin breakdown includes but not limited to: ...c. Inspection of the skin every shift with care for signs of breakdown. ...e. Keeping local areas of skin clean, dry, and free of body wastes, perspiration, and wound

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	IL6010144	A. BUILDING: _____ B. WING _____	04/05/2024

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GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S9999	Continued From page 12 drainage. ...4. Activity, Mobility, and Positioning ...h. Keep the linens dry and wrinkle free. ...9. Documentation ...d. The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers and etc ...) shall be documented in the resident's clinical records in accordance with the facility's policy and in compliance to current regulatory standards. 10. Pressure Injuries Treatment ...a. Initiate wound care treatment upon identification of the wound with physician's order. ...c. Timely referral to the facility's Wound Care Specialist for all pressure injuries and/or wounds." (B)	S9999		