(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000756	B. WING		05/	09/2024
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE		
GROVE	HEALTH & REHAB C	IR IHE	ROVE STREET SONVILLE, IL 6	52650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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		S 000			
	Annual Licensure S	Gurvey				
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations				
	300.1210a) 300.1210b)3)4)					
	Section 300.1210 Nursing and Persor	General Requirements for nal Care				
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)		at s to tal ne nest nd			
	and services to atta practicable physica well-being of the re each resident's cor plan. Adequate and care and personal of	all provide the necessary cate ain or maintain the highest all, mental, and psychological sident, in accordance with apprehensive resident care are properly supervised nursing are shall be provided to eat total nursing and personal	ng nch			

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/15/24 **Electronically Signed** 

TITLE

PRINTED: 07/23/2024 FORM APPROVED

Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  873 GROVE HEALTH & REHAB CTR, THE    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PREFIX   REALISH & REHAB CTR, THE   JACKSONVILLE, IL 62650    XAY ID   PROVIDER'S PLAN OF CORRECTION   ROUND BE   COMPLETED A THE   JACKSONVILLE, IL 62650    XAY ID   PROVIDER'S PLAN OF CORRECTION   ROUND BE   CROSS-REFERENCE TON SHOULD BE   C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
Summary statement of Deficiencies   Statement of Deficiencies   CRACH DEFICIENCY MULTER, IL. 62650	IL6000756		B. WING		05/0	9/2024	
CALL	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAJID   SUMMARY STATEMENT OF DEFICENCIES   ID   PROVIDER'S PLAN OF CORRECTION   PRETEX TAG   EACH ODERCINCH SMITS HE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   RECH CORRECTE ACTION SHOULD BE COMMETE DEFICIENCY)   COMMETE DEFICIENCY	GROVE	HEALTH & REHAB C	TR. THE		2650		
care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:  3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.  4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living on tot 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 shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.  This Requirment is NOT MET as evidence by:  Based on interview and record reviews the facility failed to promote residents' dignity by answering	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
of 11 residents (R1, R5, R6, R7 and R10) reviewed for dignity in the sample of 22. The facility failed to provide complete incontinent	\$9999	care needs of the remeasures shall included following procedures.  3) All nursing pencourage resident incontinent of bower appropriate treatments urinary tract infection normal bladder functioned shall assourced who enters the facing catheter is not cath clinical condition decatheterization was.  4) All nursing pencourage resident in activities of daily circumstances of the demonstrate that did this includes the reduces, and groom; seat; and use speed functional community who is unable to cashall receive the segood nutrition, groot this Requirment is.  Based on interview failed to promote recall lights and address of the demonstrate that did the reduced for dignity and address of the segood nutrition, groot the segood nutrition, groot the segood nutrition of the s	esident. Restorative lude, at a minimum, the lude, at a resident who is a lude or bladder receives the lude of the	S9999	DEFICIENCY)		

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED	
		IL6000756	B. WING		05/	09/2024
	PROVIDER OR SUPPLIER	IR THE 873 GRO	DDRESS, CITY, S DVE STREET DNVILLE, IL 62			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	residents (R19, R2) care in the sample Findings include:  1. On 5/6/2024 at 9 hours to get call light R1's Minimum Data documents that R1  2. On 5/6/2024 at while for call lights she needs somethiner room and staff R5's MDS dated 4/moderately impaire  3. R6's Face Sheet admission date of 1 hemiplegia, paralys R6's MDS dated 4/moderately intact.  On 5/6/2024 at 11:0 isn't enough staff, the issue. R6 stated the problem with not have that staff help her towait for a long time  4. R7's Face Sheet admission date of 3 COPD (chronic obsrepeated falls, fract R7's Minimum Data R7's Minimum Data	0) reviewed for incontinent of 22.  2:50 AM R1 stated it takes hts answered.  2:50 AM R5 stated it takes hts answered.  3:50 AM R5 stated it takes a to get answered. R5, stated if ng she will sit in doorway of will get to her when they can.  3:62024 documents that R5 is d.  3:70 AM R6 stated that there hat answering call lights is an at evening shift is the biggest aving enough staff. R6 stated to the bathroom, but she must	S9999			

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6000756		B. WING		05/0	9/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GROVE	HEALTH & REHAB C	FR. THE	E STREET	2650		
(VA) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	IVILLE, IL 6	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
S9999	Continued From pa	ge 3	S9999			
	slow to answer call aren't enough staff especially on eveni to get out bed, but i isn't enough staff to that she must wait her the bedpan, that change her, and, in always two people of the syncope, repeated and COPD.	et dated 5/9/2024 documents 12/19/2023 and diagnoses of fall, congestive heart failure 1/1/2024 documents that R10				
	On 5/6/2024 at 10:15 AM R10 stated that she has had to wait 45 minutes for her call light to be answered. R10 state the staff are good but they are always short staffed and over worked.					
		ncil Minutes, dated April 2024 nent concerns, Nursing: call				
		DAM V10, Assistant Director of ated he expects call lights to				
	documents "Reside	Il light policy dated 7/1/2023 ent call light will be responded ble amount of time."				
		Record, print date of 5/9/24, 9 was admitted on 12/4/23 and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
	IL6000756		B. WING		05/0	09/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GROVE	HEALTH & REHAB C	TR. THE	OVE STREET ONVILLE, IL 6	2650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PRO

ILG000756    B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER  GROVE HEALTH & REHAB CTR, THE    STREET ADDRESS, CITY, STATE, ZIP CODE	U 0000750		R WING		05/00/2024		
GROVE HEALTH & REHAB CTR, THE    SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGY   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGY   COMPLETE DATE   CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF I	DROVINER OR SUDDI IER				05/0	9/2024
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			873 GRO\		STATE, ZIF GODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 5 the feces. With another wet washcloth V18 cleansed the rectal area. A new incontinent brief was then placed on R20. V18 failed to cleanse the inner thighs which were noted to be red, the back of the thighs, and the buttocks.  On 5/9/24 at 11:32 AM, V2, Director of Nurse, stated that when incontinent care is provided the resident should be cleansed completely and any areas that were soiled should be cleansed. V2 further stated that if a resident has an indwelling urinary catheter the catheter tubing should be cleansed and the meatus.  The Incontinence Care Policy, dated 7/1/23, documents, "8. Wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and performing hand hygiene as required to prevent cross-contamination."			JACKSON	NVILLE, IL 6			
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Illinois Department of Public Health STATE FORM

6899 UQB211 If continuation sheet 6 of 6