Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053926	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE AT THE LAKE,THE	**2534 ELIM AVENUE , ZION, Illinois, 60099**

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: #2517144/ 2580226	S0000		08/09/2025
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)2)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. 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to assess a surgical wound and change the dressing as ordered for13 days. This failure resulted in R2 developing an infection in the left knee surgical wound requiring hospitalization and surgery on 6/3/25. This applies to 1 of 3 residents (R2) reviewed for surgical wounds in the sample of 5.	S9999		08/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 The findings include: R2's Physician's Order Sheet dated August 8, 2025 shows that she was admitted to the facility on 5/20/25 with diagnoses including Anxiety Disorder, Dementia and History of Falling. This document also shows orders for: Left Leg non-removeable dressing every day shift for wound care and an appointment scheduled with V6 (Orthopedic Physician) on 6/18/25. R2's Admission Assessment dated 5/20/25 states, "left lower leg- cast." R2's Hospital Discharge Instructions dated 5/20/25 show an order for "Dressing change every 3-5 days and as needed. Instructions: Place sheet of Xerofoam, 4x4s then Kerlix. Ace wrap from ankle to thigh. Then place splint to maintain leg extension. Then wrap from ankle to thigh again with another ace wrap to hold the splint." On 8/8/25 at 10:30AM V5 (LPN- Wound Care) stated, "She came in with a few wounds on the legs and then the surgical on the (Left) knee. When she came here she had a hard cast on and as far as I know it was not removeable It was wrapped with an Ace wrap but it was a hard cast At least I thought it was a hard cast. I was not here the day they removed it. I may have overlooked the order for the wound care when she came in. We get a lot of (V6's- Orthopedic Physician) patients and their orders say 1-2 weeks but then we call to make an appointment and we can't get in for about a month. I have talked to him a few times since the wound infection but I don't think I talked to him before. He used to be very hard to get a hold of but now I have his direct number so I can reach him a lot easier. When (R2) came in I'm sure I talked to the primary care physician and told him she had a non removeable cast and he just said ok." On 8/8/25 at 12:06PM V4 (Registered Nurse) stated, "I did the admission assessment for her. I checked the cast and I notified wound care. I don't remember seeing an order for wound care. I report to wound care and then they take over the orders from there. I don't recall her having any specific problems with the cast. She kept asking for Norco - very regularly. She did not complain of specific pain from the cast, just pain in general."	S9999		

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S9999	Continued from page 2 On 8/8/25 at 3:00PM V10 (Wound Nurse Practitioner) stated, "That info came from the patient. She was alert and oriented so I listened to what she said. (To not remove the dressing until she sees the ortho). At the time I saw her I did not have access to the orders and that is what the patient verbalized to me. I looked through the hospital record later before I finalized my note but I must have overlooked the order for treatment. In my experience I have seen physician's leave the dressing in place until the patient is seen in the office. Hers was a splint with batting, it was able to be removed but we had orders to leave it in place. 1 month would be a long time to leave the dressing in place but I go by what the surgeon says." R2's Progress Notes dated 6/3/25 state, "During wound care around 10:50 AM, a putrid odor was noted coming from the residents non-removable cast. Wound care nurse opened the cast and noted bluish black tissue with increased drainage. The writer was requested to visualize the surgical site who also noted the same. The writer immediately contacted the surgeons office and was able to speak to a nurse who stated surgeon is only in office on Wednesday and nurse will reach out to the surgical doctor who may request a call back. Following that call, the writer contacted the resident's Primary Care Physician who said "a surgeon needs to see and assess her wound immediately. This is a 100% surgical issue and no one else should touch the site besides a surgeon, preferably (V6) who is the surgeon for the resident. Follow up with the surgical office in 2 hours, if no update, send the resident to (Local Hospital) non-emergency." ... On 8/8/25 at 11:15AM V3 (Licensed Practical Nurse) stated, "She had a cast on her leg and there was a smell coming from the room. I can't recall for how long we noticed the odor. I spoke with the wound care team and then I called the MD and told him about the symptoms we were seeing. (V7- LPN Wound Care) removed the cast- I was not in the room when she did. There was this bluish, blackish greenish drainage and the wound was open. The smell got stronger when she opened the splint. She took the whole splint with her, I never saw it. Usually I am in the room but I think it was just her. " On 8/8/25 at 12:40 PM V7 stated, "She did not have a cast. She had a posterior mold with undercast padding and an ace bandage over the top. I had noticed some breakthrough drainage in the early morning so I put an ABD pad over it then that bled through. I removed the ABD and trimmed back the padding so I could see the	S9999		

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S9999	Continued from page 3 knee and I could see redness around the knee. We didn't do dressing changes on her- the order was for non-removeable dressing. We would check for circulation but there was no dressing change. It was written in the treatment orders. The ABD did not have like bright red blood on it but more like old brownish drainage. I had the nurse call the MD and we sent her to the ER. Unless I am doing the admission I do not go back and look at the admission orders. I just use the orders in the treatment record. " R2's Hospital Wound Care Progress Note dated 6/4/25 states, "Wound culture sample taken from ED, patient admitted for further evaluation and treatment for wound infection requiring IV antibiotics, with infectious disease and orthopedic consult." R2's Hospital Consultation Note dated 6/5/25 and written by V6 (Orthopedic Physician) states, "Patient presents to the ED from (Nursing Home). Patient with resent surgery 2 weeks ago on the left knee following a fall. Per staff bandage has not been removed since surgery and they noticed a foul smell, removed bandage and noticed necrotic tissue and inflammation." "73 year old female well known to service. Recent admission with large transverse laceration across leg/knee that required I&D (Incision and Drainage) with woundvac treatment. Was doing well post op and transferred to SNF. For reasons unknown, woundvac was not continued at SNF. Large Eschar and poor wound healing ensured. Patient was brought to (Hospital) and decision made to admit for more comprehensive wound care than was being offered at the SNF. Planning to repeat I &D in the OR (Operating Room). "Assessment/Plan: 1. Wound Dehiscence; 2. Wound infection". (A)	S9999		