STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ST CHARLES	611 ALLEN LANE , SAINT CHARLES, Illinois, 60174

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S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1)2) 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 300.1210 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly	S9999		

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

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S9999	Continued from page 1 administered. 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to communicate a resident's new dialysis site order to the dialysis team and assess for post-dialysis complications. This failure resulted in the resident developing acute right arm pain and swelling from his AV (Arteriovenous) fistula site and requiring hospitalization for management of an acute cephalic vein thrombosis. This applies to 1 of 3 residents (R93) reviewed for hemodialysis in a sample of 23. Findings include: On 9/23/2025 at 3:20 PM, V9 (R93's Family Member) said R93 required hemodialysis treatments. R93 was in bed with his right arm elevated on a pillow. R93's right arm had purplish discoloration throughout. R93 had an AV fistula to his right upper arm and a permcath (central vascular access catheter) to his upper chest. V9 said before R93 was discharged to the facility, he required insertion of permcath for his dialysis. V9 stated R93 experienced severe bleeding complications from his AV fistula at the hospital on 9/8/2025. R93 was then admitted to the facility on 9/09/2025. V9 said R93's hospital discharge instructions included for the facility to ensure R93's permcath be used for his dialysis treatments, and not the AV fistula. V9 said on 9/11/2025, after R93 received his dialysis treatment on 9/10/2025 (at the facility), she noted his right upper arm was severely swollen, and he was complaining of pain. V9 said she requested the nurse on duty to assess R93's arm. V9 said she was then informed his AV fistula was used for his dialysis treatment, rather than his permcath. V9 said R93 was transferred to the hospital and was treated with intravenous heparin because he had a blood clot (thrombosis) in his right arm. On 9/24/2025 at 12:20 PM, V11 (Dialysis Registered Nurse/RN) said [Dialysis Company] provided in-house hemodialysis services at the facility. V11 said the facility was responsible for providing the company's intake staff with current dialysis treatment orders for new residents prior to admission. V11 said the facility nurses were also responsible for completing the dialysis Communication Report sheet prior to each	S9999		

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S9999	Continued from page 2 treatment. V11 said the form was to communicate important resident dialysis care information, including any changes from their prior treatment and identified access sites. V11 said on 9/08/2025, R93 was admitted to the dialysis company system, and his treatment order included for him to receive his treatments via his right arm AV fistula. V11 said the facility did not update the dialysis team of R93's new hospital discharge order to now receive his treatment via his new permcath. V11 also said R93's Communication Report sheet dated 9/10/2025 did not indicate he had a new catheter site, nor his updated dialysis discharge instruction. V11 said she did not have access to R93's hospital records for review, which were uploaded into the facility's EMR (Electronic Medical Record) system. V11 said on 9/10/2025 she accessed R93's AV fistula site and dialyzed him. V11 said R93's site was stable after his treatment, but he had notable swelling to his arm. V11 said then V9 (Family Member) informed her of R93's order to use his permcath, not his AV fistula, due to his last treatment complications at the hospital. V11 said R93's nephrologist (V5) was notified of R93's swollen arm and gave orders for him to be transferred to the hospital. On 9/24/2025 at 12:40 PM, V12 (Admission Director) said the facility's intake staff was responsible for providing the dialysis company with dialysis treatment orders prior to a resident's admission. V12 said he assumed the nursing staff was then responsible for reviewing the hospital medical record of a new admission and updating the dialysis team of any new dialysis orders after admission. On 9/24/2025 at 12:50 PM, V2 (Director of Nursing/DON) said V11 (Dialysis RN) had limited access to the facility's EMR system. V2 said the access included progress notes, nursing assessments, and physician orders, but not attached hospital documents. V2 said nurses were expected to complete a comprehensive admission assessment and document any vascular access sites. V2 said nurses should also review and ensure hospital instructions were followed. V2 said if any discrepancies were identified, nurses should contact the physician or hospital discharge nurse for clarification. V2 said nurses should also be monitoring and assessing residents closely for complications after dialysis. On 9/25/2025 at 12 PM, V5 (Physician/Nephrologist) said he was contacted on 9/11/2025 regarding R93's post-hemodialysis complication to his right arm AV fistula site. V5 said the clinical team members involved in the resident's care should have appropriate	S9999		

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S9999	Continued from page 3 access to their medical record to ensure important information is communicated. V5 said the dialysis team depends on critical dialysis treatment notes and orders for review to ensure residents receive their treatments as ordered. V5 said R93's complicated stenosis from his AV fistula was most likely ongoing, and that is why his permcath was placed prior to discharge from the hospital. V5 said R93's post-dialysis complication from his treatment on 9/10/2025 could have been avoided if the dialysis team had been informed of his updated treatment orders to not use his AV fistula and only use his new permcath. R93's hospital discharge documents dated 9/09/2025 included dialysis catheter care instructions. The instructions said, "A catheter was placed into the large blood vessel in your neck…This catheter will be used for you to receive dialysis." R93's Nursing Admission/Readmission form dated 9/09/2025, said R93 was admitted to the facility for dialysis and rehabilitation services. The forms section titled Vascular Access Evaluation did not note R93's permcath and AV fistula sites. The forms section titled Baseline Care Plan for Dialysis also did not include R93's permcath access site for his treatment. R93's Order Summary Report showed his dialysis admission orders dated 9/09/2025 did not include his order to use his new permcath for his treatments. R93's hemodialysis care plan initiated on 9/17/2025, did not include the use of his permcath for his treatments. The care plan did include the interventions of "Encourage communication with dialysis center" and "Monitor access site." R93's dialysis Communication Report sheet dated 9/10/2025, did not communicate R93's last treatment complications and new access site. R93's progress note dated 9/11/2025 said "Daughter [V9] was on the bed side earlier when she notified the [NOD-nurse on duty], that [R93] was complaining of [RT-right] arm pain and some discomfort when moving. NOD noted swelling on [R93's] RT arm with a dressing intact from his dialysis. [V5] was notified." R93's readmission hospital documents dated 9/12/2025 said R93's assessment included "RUE DVT [right upper extremity, deep vein thrombosis]; RUE edema; [End-stage Renal Dialysis] Patient presented to the ED for evaluation of right arm swelling. Has RUE AVF [arteriovenous fistula] of the upper arm…Also has right	S9999		

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S9999	Continued from page 4 chest PermCath. RUE US [ultrasound]reports acute thrombus within right cephalic vein at the mid forearm. Swelling out of proportion to the size of acute thrombus. Concern for outflow obstruction, possible stenosis..." The facility's policy titled Hemodialysis dated 6/20/2025, said "It is the policy of the facility to ensure that appropriate care for residents on hemodialysis is provided by facility staff…The charge nurse may enter any new physician order in the resident's record that is requested by the hemodialysis center physician." The facility's [Dialysis Company] service contract dated 11/18/2019, said the facility's responsibilities included "Communication: [Dialysis Company] and Facility staff must communicate regularly through a defined and systematic process…Facility shall immediately inform [Dialysis Company] of any changes in the Resident's medical conditions relating to continued Dialysis Services. Facility staff shall participate in and have ultimate responsibility for Resident care planning. Ongoing communication, coordination, and collaboration between the nursing home and the dialysis staff shall be administered as described…(b) Physician/treatment orders…iii. Each Party's accessibility to the other Party's EMR provides information regarding physician/treatment orders." (A)	S9999		