

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058149		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2026	
NAME OF PROVIDER OR SUPPLIER GROVE HEALTH & REHAB CTR, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET , JACKSONVILLE, Illinois, 62650			
(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 Investigations 2642219/2784793 and 2641043/2725017		S0000			04/03/2026	
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1035e) 300.1210a) 300.1210b) 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 300.1035 Life-Sustaining Treatments e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70] Section 300.1210 General Requirements for Nursing and Personal Care		S9999			04/03/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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) 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure CPR (cardiopulmonary resuscitation) was initiated per physician's orders and resident's wishes for 1 of 3 (R16) residents reviewed for death. This failure resulted in CPR not being attempted per R16's wishes when R16 was found without a pulse or respirations. This failure has the potential to affect all 138 residents of the facility. Findings Include: R16's Admission Record with a print date of 3/24/26 documents R16 had diagnoses including hypokalemia, type 2 diabetes mellitus, emphysema, cerebellar stroke syndrome, and congestive heart failure. R16's MDS (Minimum Data Set) dated 1/2/26 documents R16 was cognitively intact. R16's Order Summary Report print date of 3/24/26 documents R16 had a Physician's order to be a full code. R16's IDPH (Illinois Department of Public Health) Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form dated 1/21/22 documents attempt		S9999				

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S9999	Continued from page 2 resuscitation/CPR, and medical interventions of full treatment with primary goal of sustaining life by medically indicated means. In addition to treatment described in selective treatment, use intubation, mechanical ventilation and cardioversion as indicated. R16's undated Care Plan documents (R16) desires CPR to be initiated in the event of cardiac arrest. Care Plan Goal: Resident wishes will be honored. In the event of cardiac arrest, CPR will be initiated and continue until EMS (Emergency Medical Services) arrival to take over compressions and/or Physician gives order to stop compressions, if not effective. R16's progress note dated 1/11/26 at 9:00 AM documents notified Dr. (V15) and (V13) daughter of R16 that resident had expired this AM. Writer was notified by CNA (Certified Nurse Assistant) around 8:20 AM that resident was no longer breathing or had a pulse. Verified with North-South Nurse that there was indeed no pulse/heartbeat and no breathing activity. On 3/23/26 at 11:44 AM V13 (R16's daughter) stated she was her mom's POA (Power of Attorney) although her mom was completely alert and oriented until she passed away. V13 stated her mom (R16) still wanted to be a full code. V13 stated she discussed her mom's code status within the last year, and her mom (R16) reiterated she still wanted to be a full code. On 3/23/26 at 12:46 PM V2 DON looked at R16's progress notes along with Surveyor and V2 stated "I do not see where CPR was initiated." V2 stated she was not the DON at the time R16 passed away. On 3/23/26 at 2:31 PM V18 LPN (Licensed Practical Nurse) stated V19 LPN called her to come down to R16's room and verify her death. V18 stated as she was going to R16's room she asked V19 if R16 needs CPR, and she thought V19 went to check R16's medical records to see if she was to receive CPR or not. V18 stated V19 came back in the room, did not say anything about R16 being a full code, so she informed V19 that R16 did not have any heart sounds nor respirations. V18 stated about 2 hours after R16 passed away she overheard V19 speaking on the phone to V15 (R16's Physician) and she heard V19 say R16 was a full code. V18 stated she then looked at R16's Physician orders and saw R16 was a full code, then she went and reported the issue to the DON. V19 stated R16 did not have any signs of rigor mortis nor any signs she had been deceased for a long period of time. On 3/24/26 at 8:58 AM V15 Physician of R16 stated he	S9999					

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S9999	Continued from page 3 would have expected R16's nurse to honor R16's wishes and initiate CPR. On 3/24/26 at 1:42 PM V19 LPN was asked by Surveyor what he did when he was alerted of R16's condition on 1/11/26 and V19 stated he did not follow protocol, someone said she (R16) took her last breath, so he went in there to check, and she wasn't breathing. V19 stated he was not aware there was an issue with R16's death until today (3/24/26). V19 stated he assumed R16 was a no code (no CPR) by the way she looked. Survey team asked V19 what R16 looked like and V19 replied "she looked like she took her last breath." V19 then stated, "I only received 2 days of orientation, I did not look at her (R16's) paperwork to see if she was a code." On 3/25/26 at 10:38 AM V30 CNA stated she found R16 unresponsive on 1/11/26 and she went to get the nurse (V19), and he (V19) told her to get the other nurse (V18). V30 stated V19 informed her R16 was a DNR (Do Not Resuscitate). On 3/24/26 at 1:55 PM V2 DON stated she expects the facility nurses to follow facility protocols. On 3/25/27 at 11:26 AM V1 Administrator stated he would have expected the nurses to administer CPR. The facility's CPR Policy dated 7/1/23 documents Emergency Procedure – Cardiopulmonary Resuscitation. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR. Instruct a staff member to activate the emergency response system (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator (if applicable). Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. The facility's Census Room Roster dated 3/25/26 documents there are 138 residents residing at the facility. (A)	S9999					