

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER GROVE AT THE LAKE LIVING AND REHABILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2534 ELIM AVENUE ZION, IL 60099
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(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
S9999	<p>Final Observations</p> <p>LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) 300.1220b)2)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal 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</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>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)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidence by:</p> <p>Based on observation, interview and record review the facility failed to provide a safe environment from residents identified with aggressive behaviors. The facility failed to follow it's Abuse policy by not restricting R30, alleged to have committed resident abuse from having direct contact with residents during an investigation. The facility's policy also failed to give direction to staff on initial reporting of an abuse allegation to the State Survey Agency. The facility also failed to prevent multiple incidents of unprovoked resident to resident physical abuse by R30 between March 1, 2013 &</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>August 12, 2013. This failure resulted in R30's unprovoked physical attack on 8/12/2013 to R34 and R18. This failure resulted in R18 sustaining facial injuries and R34 being knocked out of his wheelchair and beaten with closed fists unable to protect himself. And the 5/10/13 altercation when R22 choked R38 and held a knife to R38's neck. This applies to two of five sampled residents R18 and R22 reviewed for resident to resident altercations and four residents R30, R34, R38 and R90 in the supplemental sample. This applies to one of 20 residents (R18) reviewed for abuse in the sample of 29 and three residents (R30, R32, R34,) in the supplemental sample. The facility staff could not provide any evidence that a monitoring system was in place for R30 who remained in the facility in a three bed occupied room until 8/13/2013 evening. This has the potential to affect all 187 patients.</p> <p>The finding include:</p> <p>1. The facility's security footage viewed on 8/20/2013 at 2:00 p.m. shows on 8/12/2013 at 6:30 p.m., four residents R9, R34, R114 and R66 were seated at a table on the facility's penthouse patio smoking. R30 was seen coming through the patio door at a purposeful pace. R30 headed straight for R34 who has a right below the knee amputation and uses a wheelchair. R30 began to repeatedly hit R34 with closed fists to R34's upper body and head. One of R30's punches knocked R34 out of the wheelchair to the ground. R30 continued to repeatedly punch R34.</p> <p>No staff were seen on the patio while this attack is taking place. (E14) Activity Staff came through the patio doors about 2 minutes after the attack. E14 removed R30 from the patio and left R34 on</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>the ground. R34 was seen crawling on the ground trying to get his wheelchair that was three to five feet away. As the tape continue to run, no one was seen to come and evaluate R34.</p> <p>On 8/13/2013 at 12:30 PM, R18 said her jaw hurts and her lip was busted. R18 said she was hit by R30 during a fight that happen on Monday 8/12/2013 with R30. R18 said R30 was fighting with another resident on the patio. R30 was in line waiting for cigarettes with R18 and R92. R18 was the last resident in line. R18 said R30 left the line and went to the patio and began to beat up R34. R30 was brought back into the activity area by (E14) activity staff. R18 said she was standing behind R30 who was seated in a chair. R30 all of a sudden threw his arm up and hit R18 in the face knocking her down and split her lip and repeatedly hit her in the chest and her stomach. R18 showed the gastrostomy tube in her stomach stating it is very painful. R18 stated that the tube got pulled by R30 while he was hitting her.</p> <p>R18 said her mouth was sore and burns when she eats with the split lip. R18 said she hurt all over from the attack. R18 stated she thinks she should have been sent to the hospital but she was not. R18 said she has not been seen by the doctor or examined by any one.</p> <p>R18 said she was only given some pain medication and told to "suck it up." by the nurses.</p> <p>The nursing documentation for 8/12/ 2013, at 7 PM shows staff was informed that R18 had an incident with another resident. R18's abdomen was assessed. No drainage noted. R18 was given an as needed medication for pain and anxiety. The record does not show that the physician was notified of the incident.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On 8/13/2013 at 8 AM, R18 complained of abdominal pain. The nursing note on 8/14/2013 at 3:30 AM, shows R18 complained of abdominal pain. At 1 PM, Z4 was notified and a gastroenterologic consultation was ordered. The 8/15/2013 nursing note(no time given) shows R18 was sent to the hospital for pain in the abdomen.</p> <p>R30 was admitted to the facility 6/4/2010 with a diagnosis of Schizoaffective Disorder per the Physician's order sheet dated 8/1/13 through 8/31/13.</p> <p>R30 was observed in their room lying across the bed on 8/13/2013 at 11:45 am. R30 appeared disheveled and unshaven. R30 was asked if he wanted lunch he stated he was not hungry.</p> <p>On 8/13/2013 at 1:00 PM, (E1) Administrator / Abuse coordinator said there was an altercation with R30 that happened on 8/12/2013 and the facility was still investigating the incident.</p> <p>The facility's incident reports from January 2013 until August 2013 show R30 is identified to have had five other resident to resident altercations with R34 and R90.</p> <p>The Incident / Occurrence Report dated 5/17/2013 at 12:30 PM states:</p> <p>R30 and R90 were observed standing waiting for the elevator on the third floor. R30 started yelling at R90 for no apparent reason. R90 attempted to walk away from R30 but R30 kept yelling and swinging to hit R90 punching R90 in the arm.</p> <p>(E1) administrator witnessed the altercation and separated the residents. E1 documented on 5/17, E1 pulled R30 over</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>privately and explained to him (we) can not hit another resident. R30 understood and would not try to do it again. We will continue to monitor and watch closely for R30's behaviors.</p> <p>The facility did not provide a plan of how the facility will monitor R30's behaviors.</p> <p>The nursing notation of 5/17/2013 at 1:30pm, states the Nurse Practitioner was notified and ordered R30 to be sent to the hospital for a psych evaluation. R30 was returned to the facility at 10:10 PM on 5/17/2013 with no new orders.</p> <p>On 5/29/2013, R30 was moved to the 4 th floor where the facility's Alzheimer's and Dementia residents live, as a preventive measure to help reduce any future issues with R90. This intervention is not addressed on the plan of care.</p> <p>The incident /occurrence report dated 4/24/2013 records the incident of 4/23/2013 at 9:00 p.m. The report describes:</p> <p>R34 had been yelling in the hallway about not being able to take a shower. R30 told R34 to shut up or he would hit him. R34 told R30 to go ahead. R30 shoved R34 a couple of times before he struck R34 in the upper left chest.</p> <p>When R30 realized R92 was in the shower he reportedly hit R34. This incident was unwitnessed by staff. R34 called the police. This report is not documented in the clinical record.</p> <p>The report lists resident R17 as the only witness. The report states the (CNA's) Certified Nursing Assistants did not see anything (R30 hitting R34).</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>The facility interviewed R30 about the incident on 4/24/2013. R30 stated " There is no solution coming." R30 said he recalled punching R34 four or five times in the arm. R30 added " it may have been uncalled for."</p> <p>The nursing notation dated 3/1/2013 at 9:45 a.m. states: R30 came out of the shower room. R90 was by the elevator. Words were exchanged and R30 pushed R90.</p> <p>On 3/3/2013 at 9:30 p.m. the nursing documentation reads:</p> <p>R30 had an altercation with R90. R30 came up to R90 and started punching him in the face. R90 fell to the floor with his face down. R90 received a slight skin abrasion to his lip. The residents were separated and R30 was sent to his room to be monitored. At 11:30 p.m., R30 was sent to the hospital for a psych evaluation and was returned back to the facility at 1:25 a.m. The staff monitoring of R30 is not documented.</p> <p>On 3/8/2013 at 6:50 a.m. nursing documents:</p> <p>R30 had altercation with R90. The reason for the incident was unclear.</p> <p>The incident report dated 3/13/2013 describes R30 sat with his back to the entrance of the dining room. R90 came into the dining room cursing. R30 believed the cursing was directed toward him. R30 got up from the chair and struck R90 in the face, slight redness was noted to the left jaw. The only witness to this incident were residents R83 and R23</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>On 8/15/2013 at 10:30 am, R23 stated that there were no staff present in the dining area on third floor during the 3/8/2013 incident.</p> <p>R30's plan of care dated 3/2013 does not address the incidents of 3/1, 3/3, 3/8, 4/23, 5/17 and 8/12/2013. The care plan does not identify R30's preoccupation with R34 and R90 and females in the facility.</p> <p>The interventions on the care plan remain the same. On the next review date of 6/19/13, the goal remains the same even though the goal is not met.</p> <p>R30's plan of care for his verbally/physically abusive behavior dated 3/2013 states:</p> <p>R30 demonstrates behavioral distress related to: being challenged by mental illness and R30 appears confused and disoriented at times.</p> <p>R30's problems are manifested by :</p> <p>(These items are checked on a pre printed form)</p> <p>Verbally abusive behavior when agitated Use of profanity,demeaning statements ,verbal threats and yelling at others Physically abusive behavior when agitated Attempting to push,shove,scratch,hit,slap,kick,grab,or otherwise harm another person comment written: Behavior has increased recently and may be related to psychological and cognitive problems.</p> <p>The goal / objectives for R30 is :</p> <p>R30 will no longer exhibit physical aggression toward peers the date is stated as ongoing.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>The approaches/interventions are not individualized and the following areas are checked off:</p> <p>If the resident becomes verbally or physically abusive attempt to calm the resident by explaining that "ladies and gentlemen "do not talk/behave this way."we do not touch other people."</p> <p>If talking to the resident is not successful in stopping the behavior ,try to walk with the resident to a quiet area, away from other residents.</p> <p>Intervene by speaking calmly and professionally in a soft tone of voice . Staff should avoid raising own voice, since this tends to make the resident more upset. This may cause the situation to escalate.</p> <p>Ask the resident to calmly explain what is causing this upsetting behavior. Praise the resident for speaking calmly and appropriately.</p> <p>Compliment the resident on successfully completing meals and group activities without inappropriate behavior.</p> <p>2. The incident /occurrence Certified Nursing Assistant statement form dated 05-10-13 at 5:00 PM, shows a written statement from the staff: "we were all passing dinner trays when we turned around, we saw R 22 standing over R 38 while he ((R38) was sitting choking and holding a knife to his (R38) neck saying in Spanish " his (he is) messing with me " R 22 jumped up and with both arms around R 38's neck squeezing hard while having a knife in his hand ...".</p> <p>An undated statement from E19 reads: " I heard some residents shouting " no! no! no! and as (I) turned around I saw R 22 standing at the back of</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>another resident (R 38)and was holding him in his head on a " head lock" with his(R22's) left hand, and his right hand holding a table knife poked on R 38 neck.."</p> <p>Another undated statement from E30 (Certified Nursing Assistant) documented: "R22 jumped up and put both arms around R38 neck squeezing it hard while having a knife in his (R22's) hand yelling stop messing with me ...".</p> <p>R22 ' s Minimum Data Set of 05-09-13 showed R 22 ' s cognitive score was 14 (cognitively intact), with behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Behaviors of this type occurred 1 to 3 days. Puts others at significant risk for physical injury and significantly disrupts care and living environment. On 08-15-13 at 1:55 PM, E17 stated, " As I remember, it happened during dinner. R 38 was sitting down when R 22 approached him (from) behind and he grabbed him and head locked R 38. R 22 was delusional. I was not here at the time. It was Friday and I was not informed until Monday. I just coordinate the staff interviews. I do not recall doing any changes, updating or creating a care plan.</p> <p>There was no plan of care and interventions developed to address R 22 ' s identified behavior.</p> <p>The facility's Abuse prevention program Facility Procedures</p> <p>Item# VIII. External Reporting of Abuse and allegation of Abuse</p> <p>1. Initial reporting of abuse allegations If an allegation has been made the facility shall notify the residents's representative of the allegation and along with the the Department of Public Health by Fax or phone , notify the Regional</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>office within 24 hours after each reportable incident or accident of abuse.</p> <p>(E1) Administrator/ Abuse coordinator and (E2) Director of Nursing on 8/14/2013 were not aware of The Elder Justice Act on reporting a crime both said staff has not been trained on reporting a crime within 2 hours if the facility suspects a crime with serious bodily injury to the resident (this includes criminal sexual the crime. E1 and E2 stated all are not oriented on reporting allegations of abuse and mistreatment of residents.</p> <p style="text-align: center;">(A)</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3)5)6) 300.1220b)2) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>written, signed and dated minutes of such a meeting.</p> <p>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. 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.</p> <p>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. Restorative measures shall include, at a minimum, the following procedures: 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: 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</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidence</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>by:</p> <p>Based on observation, interview and record review the facility neglected to follow its policies for abuse prevention and Investigation of occurrences by not ensuring residents are protected from further abuse, not providing medical attention after a resident injury, and the facility's policy also failed to give direction to staff on initial reporting of an abuse allegation to the State Survey Agency. The facility neglected to have a policy and procedure to follow for incontinence care. R18 sustaining facial injuries and being sent to the hospital for evaluation of abdominal pain 3 days after being hit by R30. R133 developed a stage II pressure sore after being incontinent for 5 hours. R34 was knocked out of his wheel chair and was beaten by R30. This applies to 1 of 12 residents (R18) reviewed for incidents in the sample of 29 and 4 residents (R30, R34 and R133) in the supplemental sample.</p> <p>The findings include:</p> <p>1. On 8/13/2013 at 12:30 PM, R18 said her jaw hurts and her lip was busted. R18 said she was hit by R30 during a fight that happened on Monday 8/12/2013, at night in the penthouse, with R30.</p> <p>R18 said R30 was fighting with another resident on the patio. R30 was in line waiting for cigarettes with R18 and R92. R18 was the last resident in line. R18 said R30 left the line and went to the patio and began to beat up R34. R30 was brought back into the activity area by (E14) activity staff. R18 said she was standing behind R30 who was seated in a chair. R30 all of a sudden threw his arm up and hit R18 in the face knocking her down and split her lip and</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>repeatedly hit her in the chest and her stomach. R18 showed the gastrostomy tube in her stomach stating it is very painful. R18 stated that the tube got pulled by R30 while he was hitting her. R18 said her mouth was sore and burns when she eats with the split lip. R18 said she hurt all over from the attack. R18 stated she thinks she should have been sent to the hospital but she was not. R18 said she has not been seen by the doctor or examined by any one. R18 said she was only given some pain medication and told to "suck it up." by the nurses.</p> <p>The nursing documentation for 8/12/ 2013, at 7 PM shows staff was informed that R18 had an incident with another resident. R18's abdomen was assessed. No drainage noted. R18 was given an as needed medication for pain and anxiety. The record does not show that the physician was notified of the incident.</p> <p>On 8/13/2013 at 8 AM, R18 complained of abdominal pain. The nursing note on 8/14/2013 at 3:30 AM, shows R18 complained of abdominal pain. At 1 PM, Z4 was notified and a gastroenterologic consultation was ordered. The 8/15/2013 nursing note(no time given) shows R18 was sent to the hospital for pain in the abdomen. The facility's surveillance video from 8/12/13, shows R30 came though the patio door at a purposeful pace. R30 headed straight for R34 who has a right below the knee amputation and uses a wheel chair. R30 repeatedly hit R34 with his closed fist to his upper body and head. One of R30's punches knocked R34 out of his wheel chair to the ground. R30 continued to punch R34 while he was on the ground.</p> <p>No staff was seen on the patio while this attack was taking place. E14 (activity staff) was seen coming through the patio doors 2 minutes after</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>the attack. E14 removed R30 from the patio and left R34 on the ground. R34 was seen crawling on the ground trying to get his wheel chair that was 3 to 5 feet away.</p> <p>As the tape continued to play no one came to evaluate R34. R30 was placed in the activity room after the altercation with R34. R30 then repeatedly hit R18.</p> <p>After the altercation on 8/12/2013 R30 was kept in the facility until 8/13/2013 in a 3 bed room with other residents. The facility did not monitor R30 and did not protect other residents.</p> <p>On 8/13/2013 at 2 PM, E1 stated that he was not sure if R30 was still in the facility. E1 said the facility was having a problem with the hospital they send R30 to. They keep returning R30 to the facility.</p> <p>E1 was asked how the facility monitored R30 after this incident. E1 said he told R30 that at the next incident he would be sending him out.</p> <p>The nursing notes dated 7/15/2013 is the last until the 8/12/2013 7:45 PM incident. The nurses note does not describe how the facility monitored R30 after the altercations.</p> <p>On 8/13/2013 at 7 PM, a call was placed to another hospital for possible admission for R30. R30 was sent out at 7:30 PM on 8/13/2013 for the two resident to resident altercations.</p> <p>2. ON 8/14/2013 at 10:30 AM though 12 PM, R133 was in the dining room sitting in a wheel chair during activities, sleeping. R133 had a very strong urine odor. At 12:05 PM, R133 was taken to and left in her room. R133 was not repositioned by the staff. At 12:45 PM, E11 (Certified Nursing Assistant - CNA) transferred R133 from the wheel chair to the bed. R133's shirt and pants were soaked from mid back down to her lower thighs. R133 was dripping wet when the disposable incontinence brief was removed. A new stage II pressure ulcer was observed on the</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>left buttocks.</p> <p>At 12:47 PM, E11 explained "she (R133) does not move by herself, she does not talk at all and she is totally dependent on staff for everything (ADL's). The night shift got her up this morning, my shift starts at 7 AM. She (R133) was already up. I had not checked on her or toileted her until now (more than 5 hours).</p> <p>The facility's undated policy for Investigation of Occurrences Report: All incidents/accidents/occurrences report will be discussed and assessed to ensure all occurrences are investigated properly.</p> <p>The Procedure under number 3, Medical attention shows the nurse shall: Examine the patient, Notify the attending physician of the occurrence and document notification, notify the family member of the occurrence and document the notification. If necessary transfer the injured resident to the hospital (or preferred hospital) or call 911 if immediate help is needed.</p> <p>The facility's undated abuse procedure/abuse prevention program lists under item 6: protection of residents- The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees of the facility.</p> <p>E1 was asked for a policy on incontinence care and replied they didn't have one.</p> <p style="text-align: center;">(B)</p> <p>300.1210a)</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>300.1210b)2) 300.1210c) 300.1210d)3) 300.1220b)2)3) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal 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) 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. Restorative measures shall include, at a minimum, the following procedures: 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidence by:</p> <p>Based on observation, interview and record review, the facility failed to provide R14 with treatment/services to prevent a decline in the range of motion (ROM) for his left wrist.</p> <p>This failure contributed to R14 developing contractures of the elbow, bilateral hands and left wrist between January and August 2013.</p> <p>This applies to one of nine residents (R14) reviewed for services to maintain their range of motion, in the sample of 29.</p> <p>The findings include:</p> <p>On 8/13/13 at 12 PM, during the initial tour and on 8/14/13 at 10 AM, R14 was sitting in bed. R14's left wrist was dropped downward. R14 had a soft wrist splint lying on his bed. R14 said he would sometimes wear this soft wrist splint.</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>On 8/20/2013 at 3 PM, E13 (restorative nurse) was interviewed. After reviewing R14's contractures assessment, dated 1/27/13, 4/22/13 and 7/15/13, E13 said R14 had no limitation in function of his joints. E13 stated R14 was receiving restorative care for grooming issues and ROM (range of motion). Then, E13 went to R14's bedside and observed that R14's left wrist dropped downward at the wrist. E13 was not able to fully extend R14's left wrist. E13 stated that R14 had experienced a decrease in the range of motion to his wrist. E6 (restorative nurse) was not aware that R14's left wrist had a decline in function. E6 stated that no one told her that R14 had a problem with his left wrist and needed services.</p> <p>R14's August 2013 Physician Order Sheet (POS) showed no orders for treatment of contractures.</p> <p>R14's 1/12/13 Initial and 7/04/13 Quarterly MDS (Minimum Data Set) assessments show no functional limitation in ROM for his upper extremities (including the elbow, wrist and hand).</p> <p>R14's care plan, dated 5/09/13, shows he was at risk for the development of contractures. This care plan also states that R14 had contractures of the elbow, bilateral hands, but not the wrist. R14's care plan did not show nursing approaches and treatments for R14's wrist joint.</p> <p>On 8/21/2013, the facility presented another Contractures Assessment for R14. This new assessment showed R14's left wrist had limited function with pain. This Contractures Assessment had a date of 8/19/13, but was not on the assessment flow sheet on 8/20/13.</p> <p>On 8/13/13 and on 8/14/2013, R14 was observed</p>	S9999		
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S9999	<p>Continued From page 22</p> <p>with a dropped left wrist and not wearing any positioning device.</p> <p style="text-align: right;">(B)</p> <p>300.7010)c 300.7040a) 300.7040e) 300.7050b) 300.7050c)1)2)3)4) 300.7050e)1)2)3)4)5)6)7)8)9)10) 300.7050g) 300.7050h) 300.7060a)</p> <p>300.7010 Admission Criteria c) Unit staff shall complete a comprehensive evaluation of the resident before the resident is admitted.</p> <p>300.7040 Activities a) The unit's activity program shall use ability-centered care programming. e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.</p> <p>Section 300.7050 Staffing b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the setting,</p>	S9999		

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S9999	<p>Continued From page 23</p> <p>the severity of the dementia, and the resident's physical abilities, behavior patterns, and social and medical needs.</p> <p>c) All staff who ever work on the unit+ (e.g. nurses, housekeepers, social services and activities staff, and food service staff) shall receive at least four hours of dementia-specific orientation within the first 7 days of working on the unit.</p> <p>1) Basic information about the nature, progression, and management of Alzheimer's disease and other dementia;</p> <p>2) Techniques for creating an environment that minimizes challenging behavior from residents with Alzheimer's disease and other dementia;</p> <p>3) Methods of identifying and minimizing safety risks to residents with Alzheimer's disease and other dementia; and</p> <p>4) Techniques for successful communication with individuals with Alzheimer's disease and other dementia.</p> <p>e) Nurses, CNAs, and social services and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall attend at least 12 hours of continuing education every year, specifically related to serving residents with Alzheimer's disease and other dementia. (Completion of the 12 hours of orientation in accordance with subsection (d) of this Section may be counted as continuing education for the year in which this orientation is completed.) Topics shall include, but not be limited to:</p> <p>1) Promoting the philosophy of an ability-centered care framework;</p> <p>2) Promoting resident dignity, independence, individuality, privacy and choice;</p> <p>3) Resident rights and principles of self-determination;</p> <p>4) Medical and social needs of residents with</p>	S9999		

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S9999	<p>Continued From page 24</p> <p>Alzheimer's disease and other dementia; 5) Assessing resident capabilities and developing and implementing services plans; 6) Planning and facilitating activities appropriate for a resident with Alzheimer's disease and other dementia; 7) Communicating with families and others interested in the resident; 8) Care of elderly persons with physical, cognitive, behavioral, and social disabilities; 9) Common psychotropics and their side effects; and 10) Local community resources.</p> <p>g) For each training requirement in this Section, staff shall be evaluated to determined if they have met or exceeded stated learning objectives. Results shall be documented. h) Training requirements in this Section are in addition to requirements for nurse aide training. Orientation requirements of this Section are in addition to regular staff orientation.</p> <p>Section 300.7060 Environment a) The environment (cultural, social and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan.</p> <p>This Requirement is not met by:</p> <p>Based on observation, interview, and record review, the facility failed to provide a structured social and physical environment, with sufficient</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER GROVE AT THE LAKE LIVING AND REHABILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2534 ELIM AVENUE ZION, IL 60099
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S9999	<p>Continued From page 25</p> <p>staff that allowed the residents to safely wander and be supervised. The facility failed to have an activity program that allowed staff to work individually with residents. The facility failed to complete comprehensive pre-admission and discharge assessments. The facility failed to ensure staff received the required training to work with residents, who have a diagnosis of Alzheimer disease.</p> <p>This has the potential to effect all 41 residents (including R26, R39, R43, R22, R35, R117, R4, R122, R136, R137, R14, R38, R121, R125, R126, R128, R135) living on the Alzheimer/Special Care Unit .</p> <p>The findings include:</p> <p>1. R26's Preliminary 24 Hour Incident Investigation Report dated 5/17/2013 showed the following: R26 stated a peer (R39) approached, and told her she could not have bed pads. The peer (R39) attempted to take bed the pads away from R26, and then allegedly slapped R26 in the face.</p> <p>R26 was interviewed in her room on 8/15/2013 at 3:29 PM. R26 stated that R39 got mad at her (R26) for no reason and slapped her face. Since the incident, R26 said, "Oh, yeah I see her all the time. I see her I walk away. I think she will start trouble."</p> <p>R26's nurse (E12) was interviewed on 8/15/13 at 3:3:20 PM. E12 said R39 has Alzheimer. She (E12) also described R39 as frequently angry and wandering around the 4th floor. E12 stated that R39 was usually mad because she wanted to be with her family, and often tried to elope. E12 said she was working when the incident occurred</p>	S9999		

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S9999	<p>Continued From page 26</p> <p>between R26 and R39. E12 stated she did not witness the alleged abuse. After the incident, E12 said that R26 and R39 remained living on the same unit, but were on opposite hallways. E12 did not explained how R26 and R39 were being monitored to ensure they remained separated. E12 stated we just monitored the residents.</p> <p>2 On 8/13/2013, 8/14/2013 and 8/17/2013, R43 was observed using an ambulating device to wander between the Alzheimer Unit and the other areas of the 4th floor unit. R43 was not being redirected to the Alzheimer side of the unit by nursing staff.</p> <p>On 8/14/2013 at 1:30 PM, E15 (nurse) stated he worked full time on the Alzheimer Unit. E15 said that the Alzheimer residents wandered between the hallway of the 4th floor. E15 said staff tried to monitored them. While E15 was being interviewed, R43 walked past the nursing station from the Alzheimer side of the unit. The other nursing staff presented in the hallway and nursing station did not redirect R43 back to the Alzheimer side of the unit. E15 was asked if the Alzheimer residents were allowed to wander from their side of the unit, like R43 going down the hallway, E15 replied, " No. " Then, E15 ran to the other side of the unit and escorted R43 back to the Alzheimer side.</p> <p>3. E12 (nurse) and E40 (nurse) were interviewed on 8/15/2013 at 3:45 PM. E12 said she worked on the day shift on the Alzheimer unit. E12 explained that it was difficult to manage the Alzheimer residents, who have behaviors, while working with only two CNA's.</p> <p>E40 said she usually worked the evening shift with the Alzheimer residents. E40 stated it's hard to monitored and supervise the residents on the evening shift because they have "sun-downing", behaviors and acting out. E40 stated that nursing</p>	S9999		

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S9999	<p>Continued From page 27</p> <p>staff cannot always stay with them because they have to provide provide care to other residents. E40 said we still have to take residents to the bathroom, feed them and pass medications.</p> <p>4. E39 is another evening shift nurse working on the Alzheimer unit. E39 was interviewed on 8/20/13. E39 also described the Alzheimer residents displaying a lot of behaviors in the evening that made them difficult to manage. E39 said the two CNA's still have to provide care, while monitoring the residents.</p> <p>5. At 10:30 AM on 8/14/2013, 25 residents were observed sitting in a large circle in the day room on the Alzheimer unit. Two activity aides were present in the room. The activity staff were conducting a decision on the excision of angels. One resident was actively engaged in the discussion, but the other residents (R22, R35 and R117), sat in their chairs and did not talk. Some residents, like R133, had their eyes closed, with their head tilted back in their chair.</p> <p>On 8/16/13 at 5:10 PM, E6(the Alzheimer coordinator) could not explain why the activity was not conducted to allow residents to be engaged based on their ability to participate and their level of cognition.</p> <p>The facility's Policy, dated 2004, on Ability Centered/Activity Focused Care Programming, dated... "Procedure: 6. Activities will be designed on the individual as well as the group's interest and levels of functioning... 8. Activities will address the cognitive, intellectual, spiritual, psychosocial, and physical needs of the individual." 9. Activities will be designed based on the high, medium, and low functioning resident..." Maintaining the residents in a large group with only two activity aides did not allow for individual consideration of each resident's interest</p>	S9999		

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S9999	<p>Continued From page 28</p> <p>and ability to participate"</p> <p>6. On 8/20/13 a 1:30 PM, E6 was asked to present the preadmission assessment for the resident living on the Alzheimer unit. After reviewing R4, R122, R136 and 137's clinical record, E6 stated she did not have a pre-admission assessment. E6 provided other resident's pre-admission assessments, but the pre-admissions were not complete for R14,R38, R43, R117, R121, R125, R126, R128, R135 and R136. The pre-admission assessments were missing information in the areas of diagnosis, medication, pain, mood, behavior and background information. E6 could not identify any resident who had an assessment done to discharge them from the Special Care/Alzheimer Unit, because they did not met the care criteria.</p> <p>The facility's policy, dated 2004, for Admission Criteria to the Special Care (Alzheimer) Unit showed the following: "...2. A Pre-Admission Assessment must be completed prior to admission. Only in emergency cases will the Pre-Admission Assessment be completed after admission. However, the person will be evaluated in order to ensure proper placement. 3. The person must have one or more of the following: Memory impairment Aphasia, Apraxia, Agnosia, Disturbance in the executive thinking process (planning, organizing, sequencing, and abstract). 4. The person requires some supervision. 5. The person requires some supervision. 6. The person is able to respond to re-direction. 7. The person could benefit from structured and non-structured activity programs."</p> <p>7. On 8/20/13 at 3:55 PM, E6 (Alzheimer Unit Coordinator) provided a list of nursing staff</p>	S9999		

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S9999	<p>Continued From page 29</p> <p>working part and full time on the Alzheimer Unit. E6 also provided the 4 and 12 hour Alzheimer training . Review of the Alzheimer unit staffing and training showed not all of the staff received the required 4 hours of inservice.</p> <p>On 8/13/13 and 8/14/13, E15 (Charge Nurse) was working on the Special Care Unit and orienting another nurse to the unit. E15's name/signature was not among the names of staff attending the 4 hour or 12 Alzheimer training.</p> <p>At 4 PM on 8/20/13, the director of nursing was asked to provide yearly evaluation of the nursing staff and training. E2 said that staff's yearly evaluation and 12 hours of training had not been done, and she had no documentation to show it (yearly evaluation and training) was completed. Since residents with the diagnosis of Alzheimer were living on other units beside the Special Care Unit, E2 did not present any evidence that staff working on the other units also had the Alzheimer training.</p> <p>The facility Policy, dated 2004, on Ability Centered/Activity Focused Care Programing showed: "Procedure: ...2. Staff will receive training on ability centered/activity focused care relating to dementia..."</p> <p>The facility's Abuse Policy, undated, showed: "IV. Establishing a Resident Sensitive Environment... Staff Supervision: On a regular basis, supervisors will monitor the ability of the staff to meet the needs of residents, staff understanding of individual resident care needs, and situations... will be handled through counseling, training..."</p> <p style="text-align: center;">(B)</p> <p>300.200a)</p>	S9999		
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S9999	<p>Continued From page 30</p> <p>300.200 Inspections, Surveys, Evaluations and Consultation</p> <p>The terms survey, inspection and evaluation are synonymous. These terms refer to the overall examination of compliance with the Act and this Part.</p> <p>a) All facilities to which this Part applies shall be subject to and shall be deemed to have given consent to annual inspections, surveys or evaluations by properly identified personnel of the Department, or by such other properly identified persons, including local health department staff, as the Department may designate. An inspection, survey or evaluation, other than an inspection of financial records, shall be conducted without prior notice to the facility. A visit for the sole purpose of consultation may be announced. The licensee, or person representing the licensee in the facility, shall provide to the representative of the Department access and entry to the premises or facility for obtaining information required to carry out the Act and this Part. In addition, representatives of the Department shall have access to and may reproduce or photocopy at its cost any books, records, and other documents maintained by the facility, the licensee or their representatives to the extent necessary to carry out the Act and this Part.</p> <p>This Requirement is not met by:</p> <p>Based on interview and record review the facility failed to follow its policy and procedure for Administrative Duties and Responsibilities in the absence of Administrative Personnel in order to prevent impeding the survey process.</p>	S9999		

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S9999	<p>Continued From page 31</p> <p>This has the potential to affect all 187 residents in the facility.</p> <p>The findings include:</p> <p>The Resident Census and Condition form dated 8/3/2013 shows a census of 187.</p> <p>On 9/5/2013 at 6:45 p m , the survey team entered the facility. (E43) Receptionist was asked to contact the manager or charge nurse for the evening. E43 said she was not aware of a manager in the facility at that time but would call one of the nurses on the floor.</p> <p>E43 was over heard to contact (E41) RN, and to tell her that the Illinois Department of Public Health (IDPH) was in the building. E41 told E43 to call the Director of Nursing which she did and received no answer.</p> <p>E43 was asked to call E41 back and let her know IDPH would like to start the survey. E43 said E41 refused to come to the lobby. IDPH went to the second floor to obtain a nurse to initiate the survey. (E42) RN, was at the medication cart near the nurses station.</p> <p>IDPH identified self and asked if there was a charge person they could talk to. E42 said " There is no one in charge. I am on my way to break." Again, IDPH identified self and asked if R42 would assist in initiating the survey. E42 said " Didn't I tell you I was on my why to break." E42 was asked what was her name. E42 did not answer and began to cover her name tag with the medications and walked away. E42 returned to the nurses station with the name tag removed and began to dial the telephone.</p>	S9999		

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S9999	<p>Continued From page 32</p> <p>The incident was reported to E3 Assistant Director of Nursing upon arrival at 7:15 pm and to E2 Director of Nursing.</p> <p>E2 stated on 9/6/2013 at 11:15 am the procedure for nursing is to call E2 or E3 when IDPH enters the building and meet IDPH in the lobby to assist with the surveys.</p> <p>E2 said "currently the facility does not have Managers or Charge personnel for the evening shift. The facility is in the process of hiring".</p> <p style="text-align: right;">(AW)</p>	S9999		