Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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
S 000	Initial Comments	S 000		

Complaint investigation

1994692/IL113466

S9999 Final Observations **S9999**

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)3)
300.3240a)

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

Attachment A
Statement of Licensure Viol[illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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	Continued From page 1	S9999		

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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidence by:

Based on interview and record review the facility failed to asses and notify the physician of a change/decline from the normal baseline of 1 of 3 residents (R1) reviewed for quality of care and assessment. This failure resulted in R1 being emergently sent to the local hospital for evaluation and admitted and treated for abnormal labs to include (increased lactate level. hyperkalemia, and increase in white blood cells), R1 was transferred to ICU and required intubation.

Findings include:

Record review on facility presented health status

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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	Continued From page 2	S9999		

note by V3 (Assistant Director of Nursing - ADON) dated on 6/20/19 documented, "R1 has shown a decline in three consecutive days via Significant Change Analysis Report for ambulation, transfer, toileting and hygiene."

On 7/3/19 at 10:00 AM V3 (ADON) stated, "R1 was functionally declining and was not on his base line. I didn't notified physician, instead I notified therapist to evaluate him."

Record review on physician order sheet (POS) indicates that V9 (R1's attending physician) was not notified on R1's functional decline.

Record review on facility documentation doesn't indicate any follow up after R1's functional decline in 6/20/19 until his condition gets worse for hospitalization through 911 on 6/24/19.

Record review on facility presented health status note dated on 6/24/19 at 8:10 AM documents that R1 was sitting on the floor, lethargic having abnormal vitals: Temperature 97.2, Oxygen saturation 87 percent with 10 litter non-rebreather mask and a heart rate of 51. Facility called 911 and transferred R1 to the local hospital at around 8:00AM

On 7/3/19 at 1:35 PM V9 (attending physician) stated, "I should be notified when there is change in condition with patient. It is part of their protocol. I wasn't notified on R1's change in condition in between 6/20/19 and 6/24/19 except 6/24/19 in AM. I am reviewing R1's hospital records, R1 has elevated White blood cell count, potassium, INR, and Lactate level. So R1 was in real shock."

On 7/3/19 at 1:00 PM V7 (Emergency Room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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	Continued From page 3	S9999		

Physician) stated, "I know the patient's condition was very complicated when we received (R1) in the ER (emergency room). (R1's) lactate and potassium levels were way elevated, (R1)was intubated upon arrival and had to give multiple bolus of intravenous (IV) fluids. We started treating (R1) with three IV antibiotics. There was not even any IV lines with patient."

Record review on hospital record indicates that upon R1's arrival on 6/24/19 at 8:33 AM R1 had an elevated lactate level of 16, potassium level of 7.0, and white blood cell (Wbc) of 26.8. R1 was intubated, multiple bolus of intravenous fluids given and treated with three antibiotics.

Record review on death certificate indicates that R1 was expired on 6/25/19. Record review on facility's health status note documented on 6/25/19 that facility received a phone call from local hospital saying that R1 was expired at 12:37 AM.

Record review on facility presented policy on notification for change of condition revised on 2/10/2018 document:
Policy Statement: The facility will provide care to residents and provide notification of resident change in status
Procedures:
1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:
b. A significant change in the resident's physical, mental, or psychosocial status.

Record review on facility presented policy on General Care revised on 2/20/1017 document:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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	Continued From page 4 Policy statement: It is the facility's policy to provide care for every residents to meet their needs Procedures: 3. Assessment shall be completed per facility policy; progress notes shall be put in by exception when assessments aren't appropriate or if additional information is needed. 4. During the resident stay at the facility, the resident will be monitored for changes ... . (A)	S9999		