STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. Building B. Wing	04/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Fox Valley,the	1601 North Farnsworth Avenue Aurora, IL 60505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate the circumstances surrounding an injury of unknown origin, in accordance with facility policy, when a resident dependent on staff assistance for all ADL's (Activities of Daily Living) sustained a burn injury to the left side of her body. This applies to 1 of 3 residents (R1) reviewed for wounds in the sample of 5. The findings include:The facility filed a final report dated March 27, 2026, regarding an injury of unknown origin sustained by R1. The report showed V1 (Administrator) was informed by V2 (Director of Nursing) on March 23, 2026, that R1 had been hospitalized for medical evaluation of redness and open area to her abdomen and redness to her left flank area. R1's MDS (Minimum Data Set) dated April 1, 2026, showed R1 was severely cognitively impaired and required substantial assistance with oral hygiene, rolling side to side in bed, and upper body dressing and dependent on staff for lower body dressing, bathing, toileting, and transfer and was fed by gastrostomy tube. On April 16, 2026, at 2:15 PM, V1 and V2 both stated they had not previously viewed images of R1's burn injury nor had discussed with the Health Care Providers at the regional burn center, where R1 was treated, the extent or most likely cause of the burn injury R1 had sustained while in the facility. The facility's final report showed V1 interviewed V23 (R1's Nurse Practitioner) and V23 opined that heparin injections may cause hypersensivity or bruising on the skin and may cause chemical burns. V1 documented that R1's physician opined that an over the counter lotion that contained alpha-hydroxy acid may cause a chemical burn. The final report also showed that no staff interviewed applied the over the counter lotion to R1 and most were unaware the lotion was in R1's room. The facility's final report on a prescribed form, dated March 27, 2026, showed 6. Harm sustained, if applicable: Describe any type of physical injury. Indicate if none. The facility's documented response was none. R1's burn center record contained a Case Management Discharge Screening Evaluation dated March 24, 2026, showed that after obtaining information from the facility's hospital liaison that the likely cause of the burn injury was rash related or due to heparin use, the information was discussed with the burn service team. The Case Management note showed Per ongoing discussion with Burn Service, there is no circumstance in which (R1's) admitting injury can be confused with a rash nor would long-term Heparin injection cause a full thickness burn injury. On April 17, 2026, at 4:02 PM, V18 (APN-BC, Advanced Practice Nurse, Board Certified from the Regional Burn Center) stated R1's burn injuries included 2 separate full thickness burn wounds on the left torso flank area and was surrounded by partial thickness burn wounds in a linear pattern of distribution from the left upper back to the left upper thigh. V18 stated the facility explanation of the burn injury being caused by a lotion or use of heparin did not explain the pattern or extent of the burn injury to R1. V18 explained due to R1's age ([AGE] years old) with R1's comorbidities, R1's skin was more fragile and much thinner than an average adult and R1's skin could be injured more easily. V18 stated the mechanism of injury would be contact.V18 stated due to R1 being NPO (Nothing by mouth) and having a gastrostomy feeding tube, there was less likelihood of R1's injury caused by a hot beverage spill and more likely due to contact with gastric contents or scalding from very, very, hot water temperature during bathing. On April 17, 2026, at 9:04 AM, V19, (CNA) stated she was the caregiver for R1, on March 21, 2026, during (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 10:00 PM to 6:00 AM shift. V19 stated it was the first time she had cared for R1. V19 stated she provided care to R1 without assistance and was unaware that R1 usually was provided care with 2 caregivers. V19 stated R1 refused to be repositioned and V19 had difficulty trying to change R1's incontinence brief. V19 stated R1 had a feeding tube that was leaking every time R1 attempted to provide care at 2:30 AM and 4:00 am. V19 stated she noticed the leaking liquid was dripping to the left side of R1's abdomen but was only able to wipe the liquid from the top of R1's abdomen. V19 stated she did not report the feeding tube leaking to the nurse because she thought the leaking was normal. V19 also stated she was interviewed during the investigation regarding the burn injury sustained by R1. V19 reported she informed the facility during the interview regarding R1's gastrostomy tube leaking during the shift worked on March 21, 2026. R1's physician orders showed R1's enteral feeding orders initiated on January 8, 2026, was bolus feeding and flush scheduled for 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. There was no scheduled flush or feeding during the overnight shift. The facility's final investigation report dated March 27, 2026, regarding an injury of unknown origin sustained by R1 contained an interview by V19. The investigation report did not include V19's statement regarding R1's gastric tube leaking during the overnight shift of March 21, 2026, prior to the burn injury discovered on March 22, 2026. The Facility's policy titled Care Guidelines for Accidents/Incidents dated February 1, 2026, showed Statement: The facility ensures the proper investigation and reporting of all accidents and incidents.Investigative actions: c. Assess the date, time location and circumstances surrounding the incident or accident .Injuries of unknown origin .Investigation must explore all possible risk factors /related circumstances related to the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect a resident dependent on staff for all ADLs (Activities of daily Living), from obtaining full thickness burns on the left side of her torso and partial thickness burns that extended from left upper back to top of the left thigh. This applies to 1 of 3 residents (R1) reviewed for wound care in the sample of 5. This failure resulted in R1 being transferred from the facility to the local emergency room on March 22, 2026, and then transferred to the regional specialty burn center. R1 was admitted to the regional burn center from March 23 through March 26, 2026, with 3% full thickness burns to the left abdomen/flank area with partial thickness burns surrounding the 2 areas of full thickness burn wounds from the left upper back to the left upper thigh. The Findings include:On April 17, 2026, at 4:02 PM, V18 (APN-BC, Advanced Practice Nurse, Board Certified from the Regional Burn Center) stated R1's burn injuries included 2 separate full thickness burn wounds on the left torso flank area and was surrounded by partial thickness burn wounds in a linear pattern of distribution from the left upper back to the left upper thigh. V18 stated the facility explanation of the burn injury being caused by a lotion or use of heparin did not explain the pattern or extent of the burn injury to R1. V18 explained due to R1's age ([AGE] years old) with R1's comorbidities, R1's skin was more fragile and much thinner than an average adult and R1's skin could be injured more easily. V18 stated the mechanism of injury would be contact.V18 stated due to R1 being NPO (Nothing by mouth) and having a gastrostomy feeding tube, there was less likelihood of R1's injury caused by a hot beverage spill and more likely due to contact with gastric contents or scalding from very, very, hot water temperature during bathing. R1's EMR (Electronic Medical Record) showed R1 was originally admitted to the facility on [DATE], and most recently readmitted to the facility on [DATE]. R1's record showed R1 had multiple diagnoses including cerebral infarction due to unspecified occlusion of the left middle cerebral artery with hemiplegia and hemiparesis affecting the right dominant side, dysphagia, type 2 diabetes, chronic diastolic congestive heart failure, and presence of unspecified burns. R1's MDS (Minimum Data Set) dated April 1, 2026, showed R1 was severely cognitively impaired and required substantial assistance with oral hygiene, rolling side to side in bed, and upper body dressing and dependent on staff for lower body dressing, bathing, toileting, and transfer and was fed by gastrostomy tube. On April 14, 2026, at 1:24 PM, V3 (R1's grandson) stated he had visited R1 on March 19, 2026, in the evening and had purchased an over the counter lotion for dry skin for R1. V3 stated he put R1's name on the bottle and left the bottle at the bedside in hopes staff would apply the lotion to R1's dry skin. V3 stated he did not apply the lotion but left the bottle at R1's bedside. V3 stated the next time he visited R1 was on Sunday March 22, 2026, in the afternoon. V3 stated when he arrived around 3:00 PM he was concerned because R1 was lying in bed and had not gotten up in the wheelchair which was unusual for R1. V3 stated he asked the facility staff why R1 was still in bed at that time in the afternoon and staff told him that R1 had been acting feisty and had not allowed staff to get R1 up that day. V3 explained R1 was not able to talk since R1 had the stroke but could communicate with gesture and facial expression. V3 stated he asked R1 why she had not gotten up that day and stated in response R1 turned her eyes away from him and V3 described he thought R1 was trying to express something was wrong but did not understand what R1 may be trying to say. V3 stated he left the facility around 4:00 PM when staff came to change R1's incontinence brief. V3 stated he received 3 calls after he left the faciity on March 22, 2026. V3 stated around 4:30 PM he received a voice mail message from a facility nurse that stated R1 had developed a rash on the left side of her abdomen but it was not serious. V3 stated the next call he received was around 7:30 PM from a different nurse who stated they were sending R1 to the emergency room per physician order due to the rash. V3 stated the next call he received was around 2:00 AM from the emergency room physician who stated R1 had 3rd (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	degree burns to the left side of her abdomen but there was no explanation from facility staff as to how the burn injury had occurred. V3 stated on March 23, 2026, he spoke to the burn center physicians who had asked V3 how the burn injury had happened and V3 stated he had not been informed from the facility that R1 had sustained a burn injury and had only been told that R1 had a rash. V3 relayed that the physicians at the burn center had told V3 that the facility explanation of how the injury occurred was due to the lotion he had brought to the facility or a reaction from the use of heparin, that R1 had been receiving for months. V3 stated the burn center physicians told him neither of those explanations was the cause for the extent of the burn injury to R1. On April 17, 2026, at 9:04 AM, V19, (CNA) stated she was the caregiver for R1, on March 21, 2026, during the 10:00 PM to 6:00 AM shift. V19 stated it was the first time she had cared for R1. V19 stated she provided care to R1 without assistance and was unaware that R1 usually was provided care with 2 caregivers. V19 stated R1 refused to be repositioned and V19 had difficulty trying to change R1's incontinence brief. V19 stated R1 had a feeding tube that was leaking every time R1 attempted to provide care at 2:30 AM and 4:00 am. V19 stated she noticed the leaking liquid was dripping to the left side of R1's abdomen but was only able to wipe the liquid from the top of R1's abdomen. V19 stated she did not report the feeding tube leaking to the nurse because she thought the leaking was normal. R1's physician orders showed R1's enteral feeding orders initiated on January 8, 2026, was bolus feeding and flush scheduled for 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. There was no scheduled flush or feeding during the overnight shift. On April 15, 2026, at 2:37 PM, V7 (CNA) stated she assisted V6 (CNA) on March 22, 2026, around 4:00 PM, to change R1's incontinence brief. V7 stated R1 was lying on her left side when V7 came to change R1's incontinence brief. V7 stated R1 requires 2 staff during care due to R1 pushing at staff with both arms against staff and stated R1 was very strong. V7 stated she was on the left side of R1's bed and V6 was on the right side of R1's bed to change her. V7 stated as they turned R1 to position her on her back to change her, V7 noted the left side closure tab of the brief was wet, and when she removed the tab from the brief, she saw whitish and red discoloration of the skin on the left side of R1's abdomen and told V6 to go get the nurse. V7 stated she had never seen anything like that discoloration on the skin before. On April 15, 2026, at 2:54 PM, V6 stated on March 22. 2026, during the 2:00 PM to 10:00 PM shift, he was assigned to care for R1. V6 stated R1 required 2 caregivers when providing care and requested V7's assistance to change R1. V6 stated at the beginning of the shift, V3 was present and when V7 told V3 they were going to change R1, V3 ended his visit and left the room. V6 stated after they turned R1 from the left side to the back and V7 opened the brief, V6 stated V7 told him to go get the nurse right away. V7 stated he found V26 (Day shift RN) and V5 (Evening shift LPN) at the medication cart doing the change of shift count. V7 stated V26 and V5 came with him to the room. After looking at the discolored area on R1, V26 told V7 that R1 had a rash. V6 stated he had cared for R1 the day before, March 21, 2026, during the 2:00 PM through 10:00 PM shift and reported he did not see any skin discoloration or rash on the left side of R1's torso. V6 stated later in the shift, after dinner on March 22. 2026, V5 told V6 to prepare R1 to go to the hospital. On April 15, 2026, at 3:15 PM, V5 stated she was the nurse on March 22, 2026, 3:00 PM to 11:30 PM shift assigned to R1. V5 stated V26 informed V23 (NP-Nurse Practitioner for R1's attending physician) and sent a picture of the discolored area on R1's skin. V5 stated the area on R1's left abdomen and side had white and red discoloration with no blood present. V5 stated she received a call from V23 instructing V5 to send R1 to the hospital emergency room. V5 stated R1 was transferred to the local hospital emergency after ambulance transportation was arranged. V5 stated she notified V3 (R1's grandson) and V2 (Director of Nursing) of R1's transfer to the hospital. The facility provided documentation that showed R1 received bed baths and not showers and the last bed bath R1 had received occurred on March 19, 2026. On April 15, 2026, at 1:56 PM, V13 (CNA) stated she formerly worked at the facility and gave R1 a bed bath on March 19, 2026, during the day shift and was assisted by V15 (CNA). Both V13 and V15 stated the water used to bathe R1 was a comfortable temperature. On April 16, 2026, at 2:15 PM, V1 (Administrator) and V2 (Director of Nursing) reviewed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	images of R1's burn injury taken on March 22, 2026, at the local emergency room and images taken on March 23, 2026, at the regional burn center, and each stated they had not viewed images of R1's burn injury previously. V1 stated the facility was informed on Monday, March 23, 2026, by the regional burn center that R1 had sustained a burn injury in the facility. V1 stated she and V2 went to the room R1 had resided in and did not see a heating pad or were able to identify any source for R1's injury. V1 stated they started an investigation. V1 and V2 stated the only conclusion they reached was that R1's burn injury was caused by the over the counter lotion or administration of heparin. On April 16, 2026, at 2:35 PM, V23 (NP) reviewed image of R1's burn injury taken on March 22, 2026, from the local emergency room and identified the wounds as a third degree full thickness burn. V23 stated the image from the emergency room was very similar, the lighting may have been different, to the image she had received from facility on the evening of March 22, 2026, prior to ordering R1 be sent to the hospital. The facility submitted a report to the department (IDPH) dated March 27, 2026, identified as the final investigation report of injury of unknown origin to R1. The report showed 6. Harm sustained, if applicable: Describe any type of physical injury. Indicate if none. The facility's documented response was none. The facility's report concluded that R1's burn injury was caused by the over the counter lotion or the administration of heparin and implicated V3 had potentially applied the over the counter lotion to R1. The facility's report also showed that all staff interviewed denied applying the lotion or had knowledge the lotion was in R1's room. The facility's policy titled Hazards reviewed June 30, 2025, showed It is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain urology recommendations for catheter changes, failed to prevent urinary tract infection, failed to change a catheter when needed, and failed to complete comprehensive assessment for indication of catheter use for residents with indwelling urinary catheter. This applies to 2 of 3 residents (R2 and R3) reviewed for catheter use in the sample of 5. The findings include:1. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], with multiple diagnoses including diabetes type 2, hemiplegia affecting the left non dominant side, benign prostatic hypertrophy, and chronic obstructive pulmonary disease. R2's MDS (Minimum Data Set) dated March 26, 2026, showed R2 was severely cognitively impaired and required assistance with ADLs including substantial assistance with eating, oral hygiene, personal hygiene and upper body dressing, and dependent on staff for toileting, bathing, lower body dressing, bed mobility and transfer. R2 had an indwelling urinary catheter for obstruction due to prostramegaly. R2's urology clinic progress note dated January 7, 2026, showed R2 had severe prostramegaly with an elevation at the base of the bladder and recommended catheter changes every 3-4 weeks at the clinic. The clinic progress note referred R2 to a urologist office closer to the facility for follow up care. On April 15, 2026, at 3:30 PM, V4 (LPN) stated while working the 2:00 PM -10:00PM shift on March 30, 2026, R2's sister approached V4 and complained R2's urine had a foul odor. V4 stated he changed the drainage bag and flushed R2's catheter with 50 cc normal saline. There was no physician order to flush the catheter. There was no documentation in R2's progress note on March 30, 2026. On April 14, 2026, at 3:08 PM, V17 (RN) stated while assigned to R2 on March 31, 2026, during the 3:00 PM-11:00 PM shift, V17 noted R2 had blood in the urinary drainage bag. V17 stated upon further assessment, R2 was complaining of pain in his genital area and V17 noted the securement device attached to the catheter was too taunt and causing pulling on the catheter. V17 repositioned the securement device, flushed the catheter, and obtained a urine specimen to be sent to the lab. V17 stated R2 expressed relief from the pain and there was no longer blood in the catheter after flushing and repositioning of the catheter. On April 15, 2026, at 3:08 PM, V4 also stated that on April 1, 2026, V4 worked the 2:00-10:00 PM shift and was assigned to care for R2. V4 stated R2's sister approached V4 and stated she wanted R2 sent to the hospital for a catheter change because she was unable to accompany R2 on an appointment to Chicago clinic for a catheter change. V4 contacted R2's Health Care Provider and received the order to transfer R2 to the hospital for a catheter change. V4 stated the next scheduled urology appointment was scheduled for April 21, 2026. R2 was transferred to the hospital on April 1, 2026, at 7:00 PM. V4 explained the day shift nurses make the follow up appointments. V4 stated the appointments that are scheduled are kept with the daily report. V4 stated he did not recall if R2 had a scheduled clinic appointment on April 1 and had no documentation to show past scheduled appointments. R2's progress note dated April 2, 2026, at 1:06 AM showed R2 was admitted to the hospital for cystitis and prostatitis. R2's progress note dated April 3, 2026, at 6:38 PM showed R2 was readmitted to the facility on antibiotics for a urinary tract infection. R2's EMR had no assessment completed for indication of indwelling urinary catheter use or ongoing assessment of need for use or plan for removal. On April 15, 2026, the facility was unable to provide a complete comprehensive assessment for catheter use upon request. R2's physician orders had no order to address catheter change. On April 15, 2026, at 10:35 AM, V2 (Director of Nursing) stated the last time R2's catheter was changed was January 27, 2026, in the local emergency room. V2 stated R2's next urology clinic appointment was scheduled for April 21, 2026. V2 stated R2 had a cystoscopy done on February 18, 2026, and was unsure if the catheter had been changed at that time. V2 was unable to provide documentation that R2 had catheter changes in the urology clinic every 3-4 weeks in accordance with the urology clinic recommendations, between January 27, 2026, and the next (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled appointment on April 21, 2026. On April 14, 2026, the facility provided a list of residents who attended outside appointments from January 1 to April 14, 2026. R2 was listed as having attended appointments on January 7, 2026, and February 18, 2026. 2. R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with multiple diagnoses including cervical disc degeneration, adult failure to thrive, type 1 diabetes, uninhibited neuropathic bladder, and personal history of malignant neoplasm of the breast. R3's MDS (Minimum Data Set) dated March 10, 2026, showed R3 was moderately cognitively impaired and was dependent on staff assistance with ADLs including eating, oral and personal hygiene, bathing, dressing, toileting , bed mobility and transfer and dependent on staff for mobility. R3 had a sacral pressure ulcer stage 4 and an indwelling urinary catheter. On April 14, 2026, at 2:58 PM, R3 was observed lying in bed with indwelling catheter tubing that was cloudy in color and contained sediment. On April 15, 2026, at 10:00 AM, R3's catheter tubing appeared cloudy and contained sediment. V14 (LPN Wound Care Nurse) stated the catheter should be changed when the catheter stops draining or there is sediment in the tubing and added that catheter looks like it should be changed now. R3's physicians order dated March 4, 2026, showed to change the catheter and drainage bag when nonfunctioning. On April 15, 2026, The facility was unable to provide a completed comprehensive assessment for catheter indication of use and plan for removal of the catheter upon request. On April 15, 2026, at 10:35 AM, V2 (Director of Nursing) stated the expectation is for staff to change the urinary catheter when there are signs of obstruction, the catheter is not draining or there is sediment in the tubing. The facility's policy titled Indwelling Catheter dated June 30, 2025, showed 2. An indwelling catheter assessment will be filled out by the nurse.3. A physician's order will be obtained.4 A care plan for the use of the indwelling catheter will be made.9.An indwelling catheter may be changed PRN. Urine bag will be changed PRN.