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	03/27/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement hand hygiene, wear PPE (personal protective equipment) when rendering care and handling linen. This applies to 5 of 5 (R59, R75, R22, R27, and R66) residents reviewed for infection control in sample 25. The findings include:. 1.R59's EMR (Electronic Medical Record) showed R59 was admitted to the facility on [DATE], with diagnosis of peripheral vascular disease, hypertensive heart disease, acquired absence of right leg below knee, anemia, and retention of urine. On 3/25/2026, at 8:58 AM V4 CNA (Certified Nursing Assistant) after applying for PPE (Personal Protective Equipment) entered room of R59 with supplies for incontinence care in hand. V4 Removed blanket, raised the bed to the appropriate height, and removed the soiled diaper. V4 used perineal wipes to clean resident in the front of perineal area. Turned residents to the side. Changed gloves did not complete hand hygiene and used perineal wipes to clean buttock area. V4 Changed gloves did not complete hand hygiene. Grabbed a clean diaper, bed pad, and fitted sheet. V4 removed soiled fitted sheet from half of the bed did not remove gloves did not complete hand hygiene. Applied clean fitted sheet, bed pad and diaper to other half of bed. V4 turned resident over to the alternate side removing soiled linen. V4 placed soiled linen on top of garbage can. V4 turned resident and applied clean sheet to the bed. V4 removed gloves, applied new gloves, did not complete hand hygiene. V4 removed PPE gown and gloves. Did not complete hand hygiene. Applied new gloves grabbed soiled lined took to soiled linen container in hallway without placing soiled linen in plastic bag for transport removed gloves did not complete hand hygiene. R59's care plan, dated 2/10/2026, showed R59 required EBP (Enhanced Barrier Precautions) related to left groin abscess. Interventions include: to change gown and gloves before caring for next patient. Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. 2. R75's Electronic Medical Record (EMR) showed R75 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes mellitus, chronic kidney disease, paraplegia, and peripheral vascular disease. R75's Minimum Data Set (MDS) dated [DATE] showed moderately impaired cognition. The MDS further showed R75 is incontinent of bowel and bladder and requires total assistance with activities of daily living (ADLs), including perineal care. R75's care plan showed R75 is on Enhanced Barrier Precautions (EBP) related to an unstageable sacral pressure injury. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/2026 at 10:05 AM, V16 (CNA) was observed with R75 providing perineal care without wearing a gown. V16 did not perform hand hygiene before or after resident care. Following care, V16, while wearing the same soiled gloves, carried a bag of soiled linen into the hallway, opened the soiled utility room door, and discarded the items. V16 then removed gloves and did not perform hand hygiene. 3. R22's EMR showed R22 was admitted to the facility on [DATE] with diagnoses including multiple chronic ulcers of the lower extremities and atherosclerosis with ulceration. R22's MDS showed impaired cognition and incontinence of bowel and bladder. R22's MDS showed R22 requires substantial to total assistance with ADLs, including perineal care. R22's care plan dated 3/26/2025 showed R22 is on EBP related to multiple lower extremity wounds colonized with multidrug-resistant organisms (MDROs) as well as a left subclavian permacath (hemodialysis site). On 3/24/2026 at 10:40 AM, V18 (CNA) was observed with R22 providing perineal care wearing gloves only and without a gown. V18 did not perform hand hygiene before or after resident care. 4. R27's EMR showed R27 was admitted to the facility on [DATE] with diagnoses including osteoarthritis, atrial fibrillation, heart failure, diabetes mellitus, hypertension, major depressive disorder, and chronic kidney disease. On 3/25/2026 at 10:53 AM, V17 (CNA) was observed with R27 providing perineal care. Following care, V17 did not bag soiled washcloth and left them at foot of R27's bed, draped over the footboard and low air loss mattress pump. The soiled washcloths were observed to be in contact with R27's feet and bed linens. V17 then removed R27's soiled brief and did not place them in a bag. V17 then tossed the soiled brief across the bed over R27 toward the trash receptacle. The brief missed the receptacle and landed on the floor. V17 did not perform hand hygiene before or after resident care. 5. On 3/24/2026, at 11:22 AM V5 (LPN/Licensed Practical Nurse) walked in room with EBP sign on door to check blood sugar. V5 donned a pair of gloves, performed blood glucose check on R66. V5 failed to wash her hands after removing her gloves and before walking out of R66's room to touch the nursing cart. On 3/26/2026, at 8:57 AM V2 (DON/ Director of Nursing) said a EBP (Enhanced Barrier Precaution) sign hangs on the outside of the door with instructions for staff and visitors before entering. V2 said incontinence care is a high contact touch activity and staff should follow infection control practices. V2 said CNAs (Certified Nursing Assistant) should don PPE (Proper Protective Equipment) before entering room if EBP sign is posted on the door. V2 said if gloves get soiled during incontinence care the CNA should remove gloves and complete hand hygiene before applying new gloves. V2 said the CNAs should change gloves when going from dirty to clean and complete hand hygiene during incontinence care. V2 said the reason the CNA should perform hand hygiene after removing gloves is to minimize the risk of infection. V2 said dirty linen should be placed in a plastic bag and taken to dirty linen hamper. The CNA should remove gloves and perform hand hygiene. V2 said nursing staff should be doffing inside the room and preforming hand hygiene before coming out. The facility's policy title EBP Enhanced Barrier Precautions (EBP) dated of 9/16/2025, showed, purpose to reduce transmission of multi-drug-resistant organisms in the nursing home. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high- contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care activities .1. The EBP requires the use of gowns and gloves during high contact resident care activities that provide opportunities to transfer XDRO's (Extensively Drug -Resistant) to staff hands and clothing. The facility policy titled Infection Prevention and Control dated 6/30/2025, showed the facility has established a policy to identify, record, investigate, control, test and prevent infections in the facility. 17. Hand hygiene must always be performed by staff before and after direct patient contact, and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing for 20 seconds will be used.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to have a process in place to ensure accuracy of a resident's personal blood glucose monitoring device and failed to accurately write parameters for a resident's blood pressure medication.This applies to 2 of 2 (R9 and R133) residents reviewed for quality care in the sample of 25.The findings include: 1.On 03/25/2026 at 2:05 PM, R133 stated he monitors his own glucose levels with his personal device and reports the result the nurse. R133 stated he has continuous glucose monitoring from a sensor attached to his skin that sends blood glucose levels to his personal cellular device. R133 stated he manages his device himself not facility staff. R133 stated the staff do not check his glucose levels with the facility device. On 03/25/2026 at 4:52 PM, V2 DON (Director of Nursing) stated R133 had not been assessed for using his personal glucose monitoring system. There is no physician order for R133 self-glucose monitoring. V2 DON stated the nursing staff should be utilizing the facility device to check and document R133's blood glucose levels. On 03/25/2026 at 5:45 PM, V20 RN (Registered Nurse) stated she and the nursing staff obtain R133's blood glucose levels from his device and document the results in the EMR (Electronic Medical Record). V20 stated R133 manages his own sensor and device, and the facility's nursing staff does not handle it. On 03/26/2026 at 12:35 PM, V5 LPN (Licensed Practical Nurse) stated the DON told her last night the nurses needed to start checking R133's blood glucose levels with the facility device. V5 stated she has no knowledge of how quality assurance monitoring is done on R133's device. V5 stated she did not know if R133 had been assessed for the competent use of his personal blood glucose monitoring device. V5 stated she did not know the name of R133's blood glucose monitoring device. V5 stated she did not have any instructions or policies for R133's blood glucose monitor device. On 03/26/2026 at 1:42 PM, V2 DON stated she was unaware the nursing staff were documenting the blood glucose reading from R133's personal device. V2 stated there is no facility policy for the use of R133 personal blood glucose monitoring system. V2 stated she did not have an instruction manual for R133's device and there had not been any staff training for R133's personal blood glucose monitoring device. R133's physician orders showed blood glucose to be monitored three times a day before meals. R133's current care plan states R133 is at risk for fluctuating blood glucose sugars due to diabetes mellitus. Interventions include blood sugar checks per physician's order. R133's MAR (Medication Administration Record) documents twenty blood glucose readings as sensors. The facility's policy Diabetes Management dated 6/30/25 showed it is the policy of this facility to provide optimal nursing care for diabetic patients to individualize teaching according to carefully assessed resident and family needs. Verify physician's order for this procedure. Follow the instructions provided by the manufacturer of the glucose monitoring system to obtain a blood glucose reading. 2. R9's Physician Order Sheet (POS) showed an order dated 3/16/2026 for Metoprolol Succinate ER [Extended Release] oral tablet 24 hour 50 MG [milligrams] – Give 1 tablet by mouth one time a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day. Hold if systolic blood pressure (SBP) greater than 110 or heart rate (HR) greater than 60. R9's Order Audit Report showed Metoprolol, prescription number 1459113, was dispensed on 3/17/2026 with directions to hold if systolic blood pressure greater than 110 or heart rate greater than 60. On 3/25/2026 at 9:10 AM, observation of R9's unit dose medication card (blister pack) labeled with prescription number 1459113 showed Metoprolol Succinate ER 50 MG tab with directions to give 1 tablet by mouth one time a day and to hold if systolic blood pressure greater than 110 or HR greater than 60. R9's Medical Professional Progress Note completed by V10 (NP-Nurse Practitioner) dated 3/17/2026 at 12:00 PM showed Continue Metoprolol ER – HOLD parameters noted.review order: likely should be hold if SBP < [less than] 110 or HR < [less than] 60.current order appears reversed). Under Medication Safety/Reconciliation Notes, V10 documented metoprolol hold parameters appear incorrect. Under Plan Summary, V10 documented clarify medication hold parameters and plan of care discussed with nursing staff. On 3/26/2026 at 11:00 AM, V10 (NP) stated she notified nursing staff and expected the order to be clarified. V10 stated the medication could be held when it should be administered, resulting in inadequate blood pressure or heart rate control. V10 further stated the medication could be administered when it should be held, placing the resident at risk for hypotension or bradycardia. On 3/26/2026 at 2:37 PM, V2 (DON-Director of Nursing) stated her expectation is that nursing staff carry out practitioner recommendations, including clarification of incorrect medication orders. V2 stated failure to carry out practitioner recommendations may result in medication errors and potential adverse effects to residents. The facility's policy titled Medication Pass (7/2/2025) stated it is the policy of the facility to adhere to all federal and state regulations with medication pass procedures.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review the facility failed to properly maintain a venous access device.This applies to 1 of 1 residents R94 reviewed for venous access devices in a sample of 25.Findings include:On 03/24/2026 at 11:03 AM, R94 displayed his left upper arm where his single lumen PICC (Peripherally Inserted Central Catheter) had been inserted. The PICC line was covered by a transparent film dressing and had a dried brown substance underneath it at the insertion site. The transparent film dressing was bubbled not in contact with his skin at the insertion site. The dressing was dated 3/16/26. R94 did not know the day or date of when his PICC line dressing had been changed. R94 stated he was getting IV (Intravenous) antibiotics twice a day.On 03/25/2026 at 4:52 PM, V2 DON (Director of Nursing) stated PICC line dressings are changed every seven days and as needed. The RN (Registered Nurse) assigned to the resident is responsible for maintaining the PICC line dressing. The PICC line dressing should have been changed when the dried brown substance was noted. If the dressing was placed on 3/16/26 it should have been changed on 3/23/26. Failing to change the dressing every seven days or when it is soiled and not secured places the resident at risk of developing a blood stream infection or if it is soiled and not secure the line may become dislodged placing the resident at risk for infiltration of fluids or medication. The nurses should not document a dressing change was done if it is not done.R94's TAR (Treatment Administration Record) documents the most recent PICC line dressing change as being completed on 3/22/26.R94's current physician orders include changing PICC line dressing every Sunday night shift.The facility policy Intravenous Therapy dated 6/30/25 states all midline catheter dressings are to be done every 7 days while following the procedure for dressing change of central lines. The outside of the dressing will then be labeled with dressing change date and time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to prevent a significant medication error.This applies to 1 of 1 residents R133 reviewed for significant medication errors in a sample of 25. Findings include:On 03/24/2026 at11:34 AM, R133 stated the prescriptions he was taking previously, he had not been receiving as they were ordered since admission to the facility. R133 stated the facility was provided with a list of the medications. R133 stated when he was at home his blood glucose was in a normal range. Since being in the facility his blood glucose readings have been too high.On 03/25/2026 at 4:35 PM, V22 QA (Quality Assurance) Pharmacist stated on 3/15/26 the pharmacy received an order for Metformin IR (Immediate Release) 500mg (Milligrams) twice daily. V22 stated the pharmacy assures there is no drug interaction for the list of medications submitted to them and they deliver the prescriptions. On 03/25/2026 at 4:09 PM, V23 Physician stated R133 was discharged from the hospital with orders. V23 stated he directed the nurse to continue and follow the hospital discharge instructions. V23 declined to answer how changes to R133's Metformin could impact his blood glucose levels.On 03/26/2026 at 12:07 PM, V2 DON (Director of Nursing) stated V19 RN (Registered Nurse) was the nurse that entered R133's metformin order incorrectly.On 03/26/2026 at 1:42 PM, V2 DON stated R133's blood glucose readings have stayed high since his admission to the facility.On 03/26/2026 at 1:59 PM, V19 RN (Registered Nurse) stated he entered R133's hospital discharge medication list and called them to V23 Physician. V19 stated he entered the regular metformin and not the extended-release metformin.R133's hospital summary of discharge medication includes metformin 500 mg 24-hour tablet take one tablet in the morning and one tablet in the evening.R133's Pharmacist MRR completed on 03/18/2026 states per hospital discharge, resident was to take metformin 500mg 24-hour one tablet two times a day. Resident now has an order for metformin 500 mg give one tablet two times a day. Please review, verify and update PCC as appropriate.R133's MAR (Medication Administration Record) shows he received nineteen doses of metformin 500mg over ten days from 03/16/2026 to 03/25/2026. R133's blood glucose from 03/15/2026 to 03/25/2026 ranged from 228 mg /dl to 458 mg /dl (Milligrams / Deciliter) The facility policy Verification of Physician Orders dated 7/3/25 states its purpose to reduce errors associated with misinterpreted verbal or telephone communications of medication orders or test results. A summary order to resume previous orders for medications shall not be accepted.