STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Grove Living and Rehab	502 North State Street Franklin Grove, IL 61031

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview, and record review the facility failed to have interventions in place to prevent a pressure ulcer, failed to identify an area of pressure before becoming a stage 3 and failed to have a new pressure ulcer assessed by the wound care provider while in the facility. These failures resulted in R39's pressure ulcer worsening. This applies to two of four residents (R39, R27) reviewed for pressure in the sample of 36. The findings include: 1. The facility face shows R39 was admitted to the facility 11/8/2024 with diagnoses to include dementia, chronic pain syndrome and edema. The Braden scale for predicting pressure sores dated 11/29/2024 shows R39 to be at risk. The facility admission assessment dated [DATE] for R39 shows her to have severe cognitive impairment, was able to walk without any mobility aides, was occasionally incontinent of bowel and bladder and required moderate staff assistance with toileting. The same assessment for R39 shows on the date of assessment she did not have any pressure sores but was at risk for them. The observations of R39 on 2/4/2025 to 2/6/2025 shows R39 to not have an air mattress to her bed. On 2/6/2025 in the afternoon an air mattress was added to R39's bed. On 2/06/2025 at 8:45AM, V3 (Licensed Practical Nurse/LPN/Wound Nurse) was observed doing wound care on R39. R39 was lying in bed on her side and V3 cleansed the wound and applied a new dressing. As V3 was doing this R39 could be heard moaning and guarding the area. The wound was irregular in shape and located between the buttock cheeks. The cheeks had to be separated to observe the wound clearly. Slough was observed at the base of the wound and the skin surrounding the wound appeared red and irritated. V3 said she was surprised when she heard R39 had a pressure sore. R39 was ambulatory but is incontinent of her bowel and bladder and needed assistance from staff with getting cleaned up. V3 said the pressure wound should have been found sooner, before becoming a stage 3 wound, but R39 can be combative with care and sometimes refuses care. The location of the wound also makes it harder to see if she is being combative. V3 said R39 will be seen by the NP next week and said she wasn't sure why she wasn't seen on the 4th. V3 said R39 should be on an air mattress for better healing and will get that done today. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Franklin Grove Living and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 502 North State Street Franklin Grove, IL 61031	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The weekly skin observation dated 1/13/2024 shows R39 had no skin issues but was extremely uncooperative during the assessment. The note shows the nurse documenting this nurse did the best assessment possible due to resident becoming agitated and combative]. No other nursing documentation was done to show the skin check was attempted again. The wound-weekly observation tool for R39 dated 1/30/2025 shows a stage three pressure ulcer to the sacrum. The date acquired shows 1/27/2025. The note shows there was slough (presence of dead yellow or white tissue) and small amounts of drainage present. The wound measured 3 CM (Centimeters) by 1.5 CM by 0.2 CM and the tissue surrounding the wound was described as maceration (skin softening or breaking down). A treatment for the wound was put in place and a note shows the resident to see the wound NP (Nurse Practitioner) on 2/4/2025. No note from that date by the NP was found. The wound-weekly observation tool dated 2/4/2025 for R39 shows the stage 3 sacral wound continues with slough and macerated tissue surrounding the wound. The wound measurements were unchanged from 1/30/2025. The note on the tool shows the resident will see the wound MD (Medical Doctor) next Tuesday. On 2/06/25 at 10:28 AM, V12 (Wound NP) said, The residents at risk should be repositioned every 2 hours, this is very important. If a new wound is found it should be seen as soon as possible by us, I'm not sure why they didn't have me see her on Tuesday when I was there. She should have been put on an air mattress right away as well. A pressure ulcer can develop quickly but I wouldn't say in one day. Usually, redness is visible for some time before it gets to a stage 3 pressure sore. On 2/06/25 at 9:40 AM, V2 (Director of Nursing/DON) said she did not want to make any excuses for why the pressure ulcer was not found until it was a stage 3, but R39 can be combative at times and does refuse care. R39 came to the facility from another nursing home and did have some issues adjusting to the new routine. V2 said R39 liked to do for herself but the staff learned that she was not doing a good job keeping herself clean. She was incontinent of bladder and bowel and would put the dirty undergarments in her drawer. V2 said the staff are now able to help her more, but she does still get combative. V2 said I would expect the staff to keep trying to observe her skin during skin checks and if one nurse can't get it done maybe the next one can. V2 said R39 has been like that with the staff. V2 said an air mattress will be put on her bed today. On 2/06/25 at 10:00AM, V6 (Certified Nursing Assistant/CNA) said she works with R39 and provides peri care to her. V6 said R39 can get aggressive with them and tries to hit them and pushes them away. V6 said she will just go back later and try again. V6 said she never noticed and redness to R39's sacral area. On 2/05/25 at 1:59 PM, V11 (LPN) said she did not feel like R39 was having a change in her condition. She recently had a flu shot and maybe that's why she was sleepier on that day V11 said R39 decides when she is up and when she stays in bed. V11 said she has not seen any change in her behaviors or condition other than the pressure sore. (continued on next page)

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Franklin Grove Living and Rehab	502 North State Street Franklin Grove, IL 61031

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A nursing progress note dated 2/6/2025 at 09:01 AM shows [Resident noted on dressing to Sacrum increased redness and tenderness to peri wound. Noted slough to wound bed with foul odor, moderate drainage noted. MD notified via phone d/t possible infection. New orders to obtain a wound culture and start resident on Augmentin 500mg BID x10days and Acidophilus probiotic x20 days. Consult with wound NP next Tuesday. Next of Kin called and left voicemail to call facility with any questions or concerns.]

A nursing progress notes dated 2/4/2025 at 12:44PM, shows a standard pressure relief mattress was in place for the resident. The note also shows the resident R39 will see the wound NP the following week. (The wound care NP was in the building on 2/4/2025 making wound rounds.)

The weekly skin checks for December shows no skin issues. The weekly skin check dated 2/3/2025 (7 days after the stage 3 pressure ulcer was found) shows no skin issues.

The POS (Physician Order Sheet) dated February 2025 shows an order dated to start 2/6/2025 for an air mattress due to sacral wound. (10 days after the pressure ulcer was found.) An order for a wound culture was also ordered on 2/6/2025 for suspected wound infection. The same POS also shows an order an antibiotic for wound infection to start 2/6/2025.

The care plan for R39 dated 11/21/2024 for potential for impairment to skin integrity shows the interventions for skin checks with care and weekly on her shower day. A care plan for resistance to care dated 1/12/2025 shows if resistant to care reassure her, leave, and return 5-10 minutes later and try again.

The facility policy with a review date of 8/29/2024 for skin conditions-Wound policy shows a licensed staff will complete a head-to-toe skin assessment weekly and as needed. The skin assessment will be documented in the clinical record on the weekly skin assessment.

The facility policy reviewed on 8/29/2024 for pressure ulcer shows to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified.
1. Prevention measures are assessed upon admission, any significant changes and at least quarterly based on the resident risk assessment. Implementation of preventive measures are based on the factors specific to each resident.

38488

2. R27's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, essential hypertension, chronic pain syndrome, hyperlipidemia, morbid obesity, osteoarthritis, difficulty walking, weakness, and anxiety disorder.

R27's Wound Practitioner Note dated 2/4/25 showed, . Referred on 12/17/24 . pressure ulcer of the left buttocks and coccyx . Preventative measures in place . has LAM (air mattress) . weight 268.8 lbs .

R27's medical record showed her weight on 2/5/25 as 266.2 lbs.

On 2/04/25 at 9:25 AM, R27 was lying in bed. R27's air mattress pump attached to the end of her bed was set on 350 lbs.

(continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/25 at 12:46 PM, V11 (LPN) said, . [R27's] wounds aren't improving like we want them to . On 2/06/25 at 8:18 AM, V3 (LPN/Wound Care Nurse) said the purpose of R27's air mattress is to alleviate pressure and it gets set by the resident's weight. V3 confirmed the air mattress was set at 350 lbs. V3 said 350 lbs is too high because R27 only weighs about 260 pounds. V3 adjusted the setting on the mattress. On 2/06/25 at 9:55 AM, V5 (Assistant Director of Nursing/ADON) said, It is my understanding is that mattress is supposed to be based on her weight and having it set too high affects the pressure. The heavier the resident is the higher it is set and the more it would be filled. Having it set too high would increase the firmness. It would be important to be set to the resident's weight because it affects how firm the mattress is, and we would like it to be providing the right amount of pressure. On 2/06/25 at 10:11 AM, V2 (DON) said, 350 lbs is too high for her, it won't do its job if it's too firm. The mattress is supposed to reduce pressure and promote wound healing. The air mattress Operations Manual showed, . Indications: [air mattress product name] pump and overlay system . is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program . Pressure-adjust knob (2) Determine the patient's weight and set the control knob to that weight setting on the control unit .

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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 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** 38488 Based on observation, interview, and record review the facility failed to ensure a dependent resident received timely incontinence care and failed to ensure a resident with an indwelling catheter maintained the drainage bag below the level of the bladder for 2 of 4 residents (R21, R12) reviewed for bowel and bladder in the sample of 36. The findings include: 1. R21's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease, hypertension, dysphagia, need for assistance with personal care, anxiety disorder, and major depressive disorder. R21's facility assessment dated [DATE] showed she has severe cognitive impairment and is frequently incontinent of bowel and bladder. R21's care plan initiated 3/31/2017 showed, . offer more frequent toileting . Toilet [R21] frequently, especially after meals and before placing in recliner or bed . R21's care plan initiated 1/24/2019 showed, [R21] is at risk of skin breakdown related to needing assistance with ADL's, decreased mobility, frequent incontinence . [R21] is frequently incontinent. Assist with toileting needs/incontinent care needs, every 2 hours and/or per resident request . Keep skin clean and dry as possible . On 2/05/25 at 12:57 PM, R21 was provided incontinence care by V6 and V7 (Certified Nursing Assistants/CNAs). R21 was assisted to a standing position from her wheelchair and there was urine puddled on her wheelchair cushion. R21's pants were saturated with urine from the buttocks area, down the back of the legs to just above the knees. R21's incontinence brief was removed and was completely saturated with urine. R21 had a strong urine smell. On 2/06/25 at 10:07 AM, V2 (Director of Nursing/DON) said, I expect them to do incontinence care every two hours . or sooner if they need it. They should be rounding back there on the memory unit because those are the more confused residents . It is important to keep residents clean and dry to prevent skin breakdown and UTIs (Urinary Tract Infections). The facility's policy and procedure with review date of 8/29/24 showed, Perineal Care; Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . 45395 2. R12's face sheet indicated that the resident last admitted to the facility on [DATE] with a past medical history not limited to: need for assistance for personal care, hypertension, obstructive and reflux uropathy, hydronephrosis, and artificial openings of urinary tract status. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/25 at 10:18 AM, R12 was observed in a reclining chair in his room with an indwelling urinary catheter in place with the tubing laid across R12's abdomen and over the arm rest of the recliner to his right side. The urine collection bag was placed next to R12's right lower thigh on the seat of the recliner that was not within a privacy bag, contained small amounts of sediment withing the tubing, and was not below the level of his bladder. R12 said that he has had a catheter for years due to his history of severe urinary tract infections (UTI). On 02/04/25 from 10:30 AM to 12:00 PM, R12 was observed multiple times by survey team self-propelling himself in a powered wheelchair throughout the hallways near the 500 unit with his urinary catheter tubing laid across his upper thighs, and the urine collection bag was hung on the armrest to R12's left side that was level to the arm rest that not hanging below the level of his bladder. The collection bag was partially placed within a privacy bag with the upper and middle portions of the bag clearly visible. During this timeframe, no staff members were observed by surveyor redirecting R12 or attempting to adjust the level of his urinary collection bag so that it was below the level of his bladder. On 02/04/25 at 12:07 PM, observed R12 enter the smaller dining room that is off the 400/500 units with his urinary catheter tubing laid across his upper thighs, and the urine collection bag was hung on the armrest to R12's left side that was hanging level to the arm rest and not below the level of his bladder. Several staff members were present in the dining room at this time. R12 then self-propelled himself out of the dining room approximately 30 minutes after he entered. No staff members were observed by surveyor either redirecting R12 or attempting to adjust the level of his urinary collection bag so that it was placed below the level of his bladder while R12 was in the dining room. Review of R12's active physician orders showed change suprapubic catheter as needed if increase in sediment, blockage, or unable to irrigate. R12's care plan last reviewed on 12/26/2024 reads in part: requires enhanced barrier precautions (EBP) related to suprapubic catheter with date Initiated of 04/09/2024. No further documentation regarding catheter care or monitoring found. On 02/04/25 from 02:00 PM to 03:00 PM, R12 was again observed multiple times by surveyor self-propelling himself with his powered wheelchair throughout the facility and on the 500 unit with his urinary catheter tubing laid across his upper thighs, and the urine collection bag was hung on the armrest to R12's left side that was level to the arm rest and not hanging below the level of his bladder with no staff redirection or education regarding collection bag being hung below the level of his bladder. On 02/05/25 at 12:15 PM, V8 (Licensed Practical Nurse) said that R12 gets verbally aggressive with staff and can be non-compliant but staff redirect and educate him daily regarding the placement level for his urine collection bag below the bladder and of it being in a privacy bag. V8 was unsure if R12's non-compliance and aggression were care planned but indicated that they should be. On 02/05/25 at 09:18 AM, 12:10 PM, and 2:16 PM, R12 was observed in the reclining chair in his room with the urinary catheter tubing laid across his abdomen and over the arm rest of the recliner to his right side. The urine collection bag was observed hanging on a garbage can next to R12 that was not within a privacy bag, and the tubing was observed on the floor between the garbage can and the recliner. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 07:56 AM, R12 was observed self-propelling himself with his powered wheelchair to the front lobby area where several staff members were present. R12's urinary catheter tubing was laid across his upper thighs, and the urine collection bag was hung within a privacy bag on the armrest to R12's left side that was level to the arm rest and not hanging below the level of his bladder. No staff members were observed by surveyor redirecting R12 or attempting to adjust the level of his urinary collection bag so that it was hanging below the level of his bladder. On 02/06/25 at 10:13 AM, V2 (Director of Nursing) said R12 likes things where he wants them and has been educated in the past regarding the placement of his collection bag. V2 added that R12 is alert, oriented and can be easily angered so most of the time, staff leave him alone and do not attempt to redirect or re-educate R12 regarding his urine collection bag being in a privacy bag and hung below the level of the bladder to avoid angering resident. V2 (Director of Nursing) also said that the indwelling catheter tubing and collection bag should be below the level of the bladder to avoid backflow of urine and prevent urinary tract infections. V2 then said that she thought these behaviors were care planned for R12 but discovered they weren't, so she revised R12's care plan yesterday (02/05/2025). At 10:25 AM, after interview with V2 (Director of Nursing), surveyor requested documentation regarding the education provided to R12, and of any non-compliance or behaviors related to his catheter care. On 02/06/25 at 10:30 AM, R12's revised care plan (02/05/2025) was reviewed and documented that the resident has suprapubic catheter obstructive and reflux uropathy with interventions not limited to: position catheter bag and tubing below the level of the bladder and away from entrance room door, may move it per his own preference; and provide privacy bag, often refuses to use privacy bag on wheelchair that was created by V2 (Director of Nursing) on 02/05/2025. No documentation was found during review of R12's medical record or provided by facility during course of this survey regarding provided education to R12, or of any non-compliance and behaviors related to his catheter care. Catheters, Emptying a Urinary Bag policy last reviewed 08/29/2024 reads in part: The purposes of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain a sterile specimen. General Guidelines not limited to: Always check tubing when emptying a urinary drainage bag to be sure there are no kinks, and that the urine is draining freely. Attach the drainage bag to the bedframe while resident in bed if allows for bag to not touch the floor. Keep the drainage bag below the level of the resident's bladder. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage.

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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 0921

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45395

Based on observations, interviews, and record reviews, the facility failed to provide residents with a safe and comfortable home-like environment that enhanced each resident's overall quality of life by not maintaining an effective preventative maintenance plan due to observing wall in resident's room with areas of visibly scraped paint throughout room; chair railing not secured to the wall that exposed nails and caused drywall dust to accumulate on the floor; multiple bathroom doors with visible deep scrapes and holes to the middle and lower portions; and the heating baseboard cover plates were not firmly attached or were missing. This failure directly affected 14 residents (R1, R5, R6, R9, R14, R16, R25, R33, R49, R50, R59, R65, R69, and R75) within 13 total rooms in a sample size of 36.

Findings include:

1. On 02/04/25 at 10:13 AM, R65 said the toilet seat in his bathroom was loose and that he has told staff about the issue several times. R65 added that he feels unsafe when sitting on the toilet and when getting up from the toilet because the seat is not sturdy and moves from side to side.

Review of R65's face sheet documented resident admitted to the facility on [DATE].

On 02/04/25 at 12:25 PM, surveyor informed V10 (Housekeeping & Laundry Director) about the loose toilet seat in R65's bathroom who said that resident's toilets are to be cleaned daily by housekeeping. V10 added that when staff find an issue or when residents have a repair request, a staff member should complete a work requisition form and submit the request to maintenance. V10 then said that she would complete and submit a requisition form by end of day for R65's loose toilet seat.

On 02/05/2024 at 11:16 AM, during interview with R49 and R50 who are roommates, surveyor observed large areas of scraped paint scattered throughout the wall that is directly behind the head of their beds, and observed a large, scraped area of paint to a portion of wall next to the room closet and across from the bathroom door. At 11:20 AM, R49 said look at the inside of the bathroom door. Surveyor observed to the inner bathroom door, deep scrapes and multiple holes to the middle and lower portions of the bathroom door. R49 said it looks like someone shot up the door and has resided at the facility for about a year with these issues that were present upon her admission. At 11:25 AM, R50 said she has resided at the facility for three years and the scraped paint and holes in the bathroom door have been present since her admission and said, it doesn't look good.

Review of R49's face sheet documented resident admitted to the facility on [DATE]. Review of R50's face sheet documented resident admitted to the facility on [DATE].

On 02/05/2024 at 12:35 PM, surveyor observed the wooden chair railing on the wall directly behind R75's bed and recliner, not secured to the wall with exposed nails behind the railing and drywall dust falling to the floor upon slightly touching the railing.

Review of R75's face sheet documented resident admitted to the facility on [DATE].

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/2024 at 12:40 PM, during interview with R59, surveyor observed several areas of scraped paint to the wall directly behind the head of R59's bed and observed to the inner bathroom door, deep scrapes, and multiple holes to the middle and lower portions of the door. R59 said that she has resided at the facility for several months and these issues have been present since her admission. Review of R59's face sheet documented resident admitted to the facility on [DATE]. On 02/05/2024 at 12:45 PM, during interview with R14, surveyor observed to the inner bathroom door of R14's room, deep scrapes, and multiple holes to the lower portions of the door. R14 said that she has resided at the facility for over a year and the holes have been present since her admission. Review of R14's face sheet documented resident admitted to the facility on [DATE]. On 02/05/2024 at 01:05 PM, R65 said the toilet seat in his bathroom is no longer loose and thanked surveyor for the assistance. On 02/05/2025 from 02:40 to 02:55 PM, surveyor performed building walk through with V4 (Maintenance Director) who said the railing to R75's wall was just fixed a few months ago and should be secured to the wall; the walls to R49 and R50's room were just painted a few months ago and should not be scraped then said he was not aware of the scrapes and holes to the bathroom doors in R14, R49, R50, and R59's rooms and that they should not be there. V4 then said he does monthly rounds throughout the facility and to all resident rooms to look for needed repairs or maintenance. Review of Preventative Maintenance policy last reviewed 10/17/2024 reads in part: maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. It is the job of all staff to identify areas of concern regarding the maintenance of the building. Preventative maintenance will occur throughout the year. Maintenance supervisor is responsible for developing and maintaining a schedule of maintenance to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Functions of maintenance personnel include but are not limited to: providing routinely scheduled maintenance service and repair to all areas. Review of Maintenance Work Request policy last reviewed 03/29/2024 reads in part: when a resident, staff member, or family member recognizes the need for maintenance services, a Maintenance Work Request form will be completed by a staff member, placed in designated place for maintenance personnel who will review work requests daily and prioritize work to be done. 36186 2. On 2/4/2025 during the initial tour of the facility, in resident rooms for (R1), (R9), (R25), (R5&6), (R69) and (R33&16), the base board heating units were observed to have face plates that were not firmly attached to the unit leaving exposed metal grids. The face plates were hanging down onto the floor in front of the units. On 2/5/2025 at 1:00 PM, R25 and R69's visitor said the face plates have been broken for a long time. (continued on next page)

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	145200	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Grove Living and Rehab	502 North State Street Franklin Grove, IL 61031

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2025 at 2:40 PM, V4 (Maintenance Director) said he was not aware of the plates being broken on the heating units in those rooms. V4 said he fixes things that are broken as the staff report them to him. V4 said he makes monthly rounds of the rooms and had not noticed this problem. The facility policy with a revision date of 10/17/2024 for preventive maintenance shows the maintenance department is responsible for maintaining the buildings in a safe and operable manner. Functions of the maintenance personnel are to complete monthly and weekly rounds.