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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Grove Living and Rehab	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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to ensure the menu was followed for the noon meal for the residents on pureed diets to 4 of 8 residents (R10, R59, R62 and R69) reviewed for dietary services in the sample of 18.The findings include: A facility document entitled Week at a Glance Menu documents, the menu for 4/13/26 showed rotisserie chicken, crispy fried potato with bacon, mixed vegetables, bread with margarine and cranberry short cake.On 4/13/26 during noon meal, R10, R59, R62 and R69 were served the noon meal but were not served the pureed bread with margarine.On 4/13/26 at 1:00 PM, V9 (Cook) said she did not know why the bread was not served to pureed residents which was part of the noon meal. On 4/13/26 at 1:15 PM, V9 (Dietary Manager) said the menu is carefully planned to ensure residents get the right balance of diet and must be served as scheduled on each meal.On 4/15/26/ at 11:30 AM, V14 (Dietician) said she reviews and approves the facility menu to ensure residents receive adequate nutritional value including the right amount of protein, carbohydrates and fats, the menu must be followed as planned.The policy entitled Menu planning dated 2017 documents, nutritional needs of individuals will be provided in accordance with the recommended dietary allowances of the food and nutrition board of the National Research Council, National Academy of Sciences through nourishing well balanced diets unless contraindicated by medical needs.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's power of attorney (POA) of a change in condition for 1 of 4 residents (R3) reviewed for change of condition in a sample of 18.The findings include:R3's Facility assessment dated [DATE] showed R3 has severe cognitive impairment.R3's urine culture results dated 4/10/26 showed R3 was positive for an Escherichia Coli (E. coli) urinary tract infection (UTI).R3's Progress notes printed 4/14/26 showed R3 started having hematuria (blood in urine) on 4/5/26. These notes showed no contact was made with V15 (R3's POA) with R3's hematuria (4/5/26), urinalysis results (4/10/26), or the initiation of an antibiotic (4/10/26).R3's Physician Order Summary printed 4/14/26 showed R3 had an order placed for Macrobid (an antibiotic) 100 milligrams, give 1 capsule by mouth every morning and bedtime for UTI symptoms for 7 days.On 4/14/26 at 10:00 AM, V15 stated they did not know R3 was being treated for a urinary tract infection (UTI) or on an antibiotic. V15 stated they were contacted by the facility about a pneumonia shot, but nothing about a UTI.On 4/14/26 at 12:30 PM, V2 (Director of Nursing) stated the memory care unit residents' POAs need to be contacted about changes in condition and/or new medications.On 4/14/26 12:52 PM, V3 (Assistant Director of Nursing) stated a POA should be contacted when a resident is placed on a new medication or has a change in condition. A UTI is a change in condition.The facility's Acute Condition Changes Policy dated 4/11/26 showed the nurse with notify the resident's family or representative when there is a change in a resident's physical, mental, or psychosocial status.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an as needed anxiety medication had a stop date for one of 18 residents (R69) reviewed for psychotropics in the sample of 18. The findings include:R69's Order Summary Report dated April 14, 2026, showed that R69 was admitted to the facility on [DATE], with diagnoses including palliative care, insomnia, restlessness and agitation, history of falling, dementia, major depressive disorder, and anxiety disorder. An order for Ativan oral tablet 0.5 milligrams (mg) give one tablet by mouth every three hours as needed (PRN) for agitation/anxiety/restlessness was started on February 10, 2026. There is no stop date on this order. On April 15, 2026, at 8:58 AM, V2 (Director of Nursing/DON) said as needed Ativan should have a stop date of 14 days. If the as needed medication is still needed, then the prescription needs to be done again. The nurse that enters the as needed order is responsible for putting in the stop date. The facility's Psychotropic Medication Policy reviewed March 21, 2025, shows, Licensed nurses will transcribe any new recommendations from the physician as received to the facility. The nurses shall enter all PRN orders with a 14 day stop date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor a non pressure wound for one of 18 residents (R4) reviewed for quality of care in the sample of 18.The findings include: R4's Order Summary Report dated April 14, 2026, shows he was admitted to the facility on [DATE] with diagnoses including history of pulmonary embolism, unsteadiness on feet, contact dermatitis, muscle weakness, pressure ulcer of sacral region, stage 4, major depressive disorder, and paraplegia. An order to monitor a callus to his right heel every day and evening shift was entered on September 16, 2025.R4's Treatment Administration Record dated April 1, 2026-April 30, 2026 shows staff signed off the treatment to R4's right heel twice a day from April 1-14, 2026.On April 13, 2026 at 11:29 AM, V4 (Licensed Practical Nurse/LPN) and V5 (Wound Care Nurse/WCN) went into R4's room to change his wound dressings. V5 removed the heel boot from R4's right foot. The was a bordered gauze dressing in place to his right heel that was dated April 8, 2026. V4 and V5 finished changing the dressings to R4 buttocks wounds then placed R4's heel boot back onto his right heel. The dressing to R4's right heel was not removed, nor was the wound observed.R4's Wound Weekly Observation Tool dated April 8, 2026 shows R4 has a callus to his right heel. The callus de-roofed revealing pink non-granulating tissue. The wound was draining serous drainage. The wound measured 0.5 cm (centimeters) X 0.5 cm with a 0.1 cm depth. The current treatment plan was triad paste with an island dressing daily and as needed.On April 14, 2026 at 1:24 PM, V5 (WCN) said R4's treatment to his right heel should be triad paste and bordered gauze. V5 said his right heel wound was not draining as much as it did from the past. V5 said she could not remember if the wound to R4's right heel was a daily treatment. V5 said that the floor nurses should be monitoring R4's heel wound. At 2:13 PM, V5 said she did not put the triad paste order in R4's physician orders so it hadn't been done since April 8, 2026. V5 said the staff should be monitoring the wound daily by removing the dressing in order to make sure the wound is not getting worse.The facility's Skin Conditions-Wound Policy reviewed February 7, 2025 shows, All caregivers are responsible for preventing, caring for, and providing treatment for skin ulcerations. The purpose: To provide treatment that promotes prevention of ulcerations and healing of existing ulceration.

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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** Based on observation, interview, and record review the facility failed to clean a pressure injury in a manner to prevent cross contamination and failed to have pressure injury preventions in place for three of four residents (R4, R30, R69) reviewed for pressure injury in the sample of 18.The findings include:1. R4's Order Summary Report dated April 14, 2026, shows he was admitted to the facility on [DATE], with diagnoses including history of pulmonary embolism, unsteadiness on feet, contact dermatitis, muscle weakness, pressure ulcer of sacral region, stage 4, major depressive disorder, and paraplegia. R4's Order Summary Report also show orders to: clean left gluteal wound x2 with wound cleanser, apply triad paste to wound beds and cover it with an island dressing, right gluteal wound: Cleanse with wound cleanser, pat dry, apply skin prep to peri-wound and apply hydrocolloid dressing, right inferior buttock wound: Cleanse with wound cleanser, apply 1/2 Strength Dakin's solution to gauze and pack lightly, cover with calcium alginate and secure with foam dressing, and to the sacrum wound: Cleanse with wound cleanser, apply 1/2 Strength Dakin's solution to gauze and pack lightly, cover with calcium alginate and secure with foam dressing.R4's Pressure Risk score dated December 11, 2025, shows he is a high risk of developing pressure injuries.R4's Wound Weekly Observation Tool dated April 8, 2026, shows R4 has a stage 4 pressure injury to his sacrum, stage 2 to his right buttock, shearing wound to his left gluteal, stage 2 to inferior left glute.On April 13, 2026, at 11:29 AM, V4 (Licensed Practical Nurse/LPN) and V5 (Wound Care Nurse/WCN) went into R4's room to change the dressings to his buttocks area. V4 removed the soiled dressings from R4 buttocks area. There were four open wounds noted on R4's buttocks area. V4 applied wound cleanser to 4 X 4 gauze and wiped all the wounds. There was yellow drainage noted to the gauze. V4 used the same gauze and wiped each wound, going from wound to wound. At 11:45 AM, V5 said that a new gauze should be used to clean each wound so that infection is not spread from one wound to the other.2. R30's Order Summary Report dated April 14, 2026, shows he was admitted to the facility on [DATE], with diagnoses including: muscle weakness, history of falling, need for assistance with personal care, abnormal posture, dementia, Alzheimer's disease, and cognitive communication deficit. Heel boots at all times dated January 8, 2025.R30's Scale for Predicting Pressure Sore Risk dated April 6, 2026 shows he is at high risk for developing pressure injuries.R30's Care-plan initiated November 21, 2022, shows R30 has potential impairment to skin integrity. R30 needs assistance to apply protective garments (heel boots to bilateral feet at all times).On April 13, 2026, at 11:08 AM, R30 was brought out to the tv room outside of the dining room. R30 was sitting in a wheelchair with socks on and no heel boots. R30's feet were on the footrests on the wheelchair. At 11:26 AM, R30 was observed with his left foot on the metal part of the wheelchair footrest, again with no heel boots in place.3. R69's Order Summary Report dated April 14, 2026 shows she was admitted to the facility on [DATE], with diagnoses including palliative care, history of falling, dementia, and heart failure. Heel protectors on at all times as tolerated dated August 13, 2025.R69's Scale for Predicting Pressure Injuries dated February 9, 2026, shows she is a high risk for pressure injuries.On April 13, 2026, at 9:27 AM, V6 and V7 (Certified Nursing Assistants/CNAs) placed R69 in bed. There was a heel boot on R69's nightstand next to her bed. V6 and V7 situated R69 in bed and covered her with a blanket. R69's heels were not elevated, nor did she have heel boots on. At 11:30 AM, R69 was observed in her chair with no heel boots on.On April 14, 2026, at 1:24 PM, V5 (Wound Care Nurse) said pressure injury prevention interventions include turning, pressure reduction mattresses, wheelchair cushions, heel boots, and geri sleeves. V5 said if residents have an order for heel boots at all times, then the heel boots should be in place.The facility's Skin Conditions-Wound Policy reviewed February 7, 2025 shows, To provide proper monitoring, treatment, and documentation of any resident with skin abnormalities, this facility understands that the resident's skin is their first line of defense against infections and strive to attain intact and healthy skin for our resident through a process of identification, monitoring, preventative, and treatment. Skin Ulcer Prevention: Use of elbow or heel protectors when appropriate.

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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. Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter tubing was kept off the floor for 1 of 4 residents (R37) reviewed for indwelling urinary catheters in the sample of 18.The findings include:R37's Care Plan with an initiated date of 4/9/24 showed R37 had a supra pubic urinary catheter.On 04/13/2026 at 10:58 AM, R37 was in a wheelchair. R37's indwelling urinary catheter tubing was dragging on the floor as R37 self-propelled himself.On 04/13/2026 at 12:02 PM, R37 self-propelled himself into the dining room. The indwelling urinary catheter tubing was dragging on the floor. On 04/13/2026 at 1:42 PM, R37 was in a common area. R37's indwelling urinary catheter tubing was resting on the floor.On 04/14/2026 at 8:44 AM, R37 was in the dining room sitting in a wheelchair. R37's indwelling urinary catheter tubing was on the floor. R37 was stepping on the tubing with his left foot.On 04/14/2026 at 12:58 PM, V13 (Certified Nursing Assistant) said an indwelling urinary catheter drainage bag and tubing should be kept off the floor for infection control issues. The facility's Catheter Care, Urinary policy (undated) showed the purpose of the procedure is to prevent catheter-associated urinary tract infections. Listed under infection control was to be sure the catheter tubing was kept off the floor.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review the facility failed to provide a resident with a plate guard for 1 of 2 residents (R8) reviewed for assistive devices in the sample of 18.The findings include:A facility assessment done on 3/20/26 showed R8 had limited range of motion to both upper extremities. R8's Order Summary Report printed on 04/14/26 showed an order that it was ok to use a plate guard. On 04/13/26 at 12:35 PM, R8 was served his meal. R8 was not provided with a plate guard. R8 held a spoon in his right hand and used his left hand to push mixed vegetables onto the spoon. Some of the mixed vegetables fell off onto the table. On 04/13/26 12:42 PM, R8 said the facility use to provide him with a plate guard but stopped providing the plate guard. R8 did not know why the facility stopped providing the plate guard. R8 stated the plate guard came in handy as food did not slide off the plate. R8 added that he could trap the food against the plate guard as he scooped up the food with the silverware. R8 said he could not move his fingers well. R8 attempted to move his fingers on his right hand. There was limited movement of his fingers.On 4/13/26 at 2:00 PM V8 (Dietary Manager) said plate guards are used for residents that have issues scooping up their food. The plate guard is used to help food from falling off the plate.On 4/14/26 at 8:35 AM, V8 said the kitchen knows to provide a resident with a plate guard because it is listed on a resident's meal ticket.R8's meal ticket (undated) listed under instructions to provide a plate guard.R8's Dietary Profile dated 12/22/25 showed R8 preferred to eat in his room because he was a messy eater.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure staff wore the required personal protective equipment (PPE) when providing care to a resident on enhanced barrier precautions. This applies to 2 of 18 residents (R37 and R50) reviewed for infection control in the sample of 18.The findings include: 1. R37's Care Plan with an initiated date of 4/9/24 showed R37 was on Enhanced Barrier Precautions for a supra pubic urinary catheter. On 4/13/26 at 11:31 AM, there was an Enhanced Barrier Precautions sign on the wall next to R37's room door. On 4/13/26 at 11:31 AM, V12 (Certified Nursing Assistant/CNA) emptied R37's urinary drainage bag. V12 had on gloves but no gown. On 4/13/26 at 11:34 AM, V12 said she emptied R37's urinary drainage bag. V12 confirmed the only PPE she wore was gloves. V12 said the only PPE needed when emptying a urinary drainage bag were gloves. On 4/14/26 at 12:58 PM, V13 (CNA) said a gown and gloves are to be worn when emptying a urinary drainage bag. The facility's Infection Control – Enhanced Barrier Precautions with a reviewed date of 3/6/25 showed enhance barrier precautions are generally indicated for residents with indwelling medical devices. Indwelling medical devices include urinary catheters. PPE of gowns and gloves should be worn prior to high contact resident care activities. High contact resident care activities included device care or use. 2. R50's Order Summary Report dated April 14, 2026 shows R50 was admitted to the facility on [DATE] with diagnoses including right femur fracture, repeated falls, and need for assistance with personal care. An order to clean small open area to the left side of his faced and place a small piece of silver alginate to the area and cover with a 2 X 2 island dressing daily was started on April 4, 2026. Place on Enhanced Barrier Precautions was entered on April 6, 2026. On April 13, 2026 at 9:40 AM, there was a sign on the door of R50's room that showed Enhanced Barrier Precautions and a dragonfly. V6 and V7 (Certified Nursing Assistants) transferred R50 into his bed via mechanical lift. There was a dressing half on to the left side of R50's face. V6 and V7 provided incontinence care to R50. V6 nor V7 wore gowns. On April 15, 2026 at 8:58 AM V2 (Director of Nursing) said any residents with a urinary catheter, percutaneous endoscopy gastrostomy tube, intravenous lines, and wounds should be on enhanced barrier precautions and staff should be wearing a gown if they are touching the resident doing cares. The purpose is to try and prevent passing on infections.