STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145307	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Lagrange Park, The	701 North Lagrange Road LA Grange Park, IL 60526

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to follow interventions to prevent falls and use equipment as per policy and procedures. This applies to 2 (R1 and R3) of 7 residents reviewed for falls and safety. The findings include:1. R1 is a [AGE] year old male who was admitted to the facility on [DATE], with the following diagnosis: bilateral osteoarthritis of the knee, strabismic amblyopia, cataracts, difficulty walking, muscle wasting, gait and mobility abnormalities, diabetes mellitus, protein calorie malnutrition, benign prostatic hyperplasia, dementia with agitation, sleep apnea, repeated falls, atherosclerotic heart disease, post-traumatic stress disorder, AFIB (irregular heart beat),and congestive heart failure.R1's current care plan dated September 21, 2025, shows R1 has a self-care deficit and is on a restorative advanced range of motion program; R1 has impaired mobility and is at high risk for falls and requires extensive assistance with one staff member for bed mobility, toileting, and transfers.Report written by V7 (registered nurse) on September 23, 2025, shows R1 was being transferred to the toilet by V5 (Certified Nursing Assistant) when R1 lost his balance and slowly slid to the floor. Facility's Initial Incident report dated September 23, 2025, written by V8 (Assistant Director of Nursing) shows at approximately 8:15 AM staff were assisting R1 from the toilet to the wheelchair when R1 lost balance and slowly slid to the floor. A body assessment was completed with R1 verbalizing pain to right rib area. R1 was assisted back to bed using mechanical lift. Pain medication was given. Post Fall Investigation dated October 13, 2025 at 10:16 AM written by V9 (Restorative Nurse/Licensed Practical Nurse) shows R1 had a witnessed fall with injury on September 23, 2025 at 9:15 AM. Root cause analysis identified general weaknesses related to recent hospitalization, poor safety awareness, and impaired decision-making. History of multiple falls at home noted. On October 15, 2025 at 12:30PM, V5 (Certified Nursing Assistant) stated she was present when R1 had a fall in the restroom. V5 said she was transferring R1 from wheelchair to toilet when R1's foot slipped as he turned to sit. V5 said she guided R1 to the floor with her arms wrapped around his stomach. V5 said the gait belt was wrapped around her waist and not R1's waist, and stated R1's fall happened quickly and she didn't have a chance to tell him to hold on to him (facilities will refute quotes), V5 said she did not think she needed to put the gait belt on R1 because he was already seated in the chair. V5 said she had been trained that gait belts should be placed under the resident's breast area and that this was not done during R1's fall.On October 15, 2025 at 1:38PM, V7 (Registered Nurse) confirmed that V5 (Certified Nursing Assistant) informed her of the R1's fall incident on September 23, 2025. V7 stated she did not witness the fall but observed R1 on the floor, R1 denied striking his head but complained of right rib pain. On October 15, 2025, at 2:09PM V8 (Assistant Director of Nursing) said the use of gait belts depends on restorative evaluation and that R1's fall resulted in a therapy referral.On October 15, 2025 at 4:00PM, V9 (Restorative Nurse/Licensed Practical Nurse) said staff are trained on proper use of gait belts and that belts should be placed around the resident's waist with two-finger space between the belt and resident's body.On October 15, 2025 at 4:10pm, V10 (Restorative Nurse/Licensed Practical Nurse) said that it is unsafe for a CNA (Certified Nursing Assistant) to transfer a resident using a gait belt around their own waist. V10 said that the transfer belt should be secured around the resident's waist with adequate spacing and should always be used during transfers with unsteady residents. 2. R3 is an [AGE] year-old female with a diagnosis's history of Dementia, Anxiety Disorder, Chronic Kidney Disease, Type 2 Diabetes Mellitus, Abnormalities of Gait and Mobility, and Lack of Coordination, and Unsteadiness on Feet who was admitted to the facility 07/17/2024.R3's current care plans-initiated July 2024 shows R3 has Impaired mobility and ADL (Activities of Daily Living) self-care performance deficit related to dementia, depressive disorder, psychotic disturbance, diabetes mellitus, hypertension, and is hard of hearing with interventions including extensive participation from one staff for transfers, assistance from staff for standing and walking, and use of a walker for ambulation. R3's current care plans initiated in September 2024 shows she is at risk for fluctuating blood sugars; she is at high risk for falls related to dementia, depressive disorder, psychotic disturbance, diabetes mellitus, hypertension, is hard of hearing and taking medications such as hypnotic, anti-hypertensive and hypoglycemics.R3's current care plan-initiated April 2025 shows R3 may have challenges secondary to declining vision, poor hearing or poor comprehension.R3's Functional Abilities assessment dated [DATE] shows she requires partial/moderate assistance from staff for moving from a sit to stand position and walking. R3's Restorative assessment dated [DATE] shows her gait is unsteady, she requires assistance with ambulation and one person assistance with

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received timely and adequate incontinence care and hygiene assistance.This failure applies to 4 of 4 residents (R1, R4, R5, and R6) reviewed for incontinence care.The findings include:1. R1 is a [AGE] year-old male who was admitted to facility on September 18, 2023.R1's face sheet includes the following diagnoses: : bilateral osteoarthritis of the knee, strabismic amblyopia, cataracts, difficulty walking, muscle wasting, gait and mobility abnormalities, dysphagia, diabetes mellitus, protein calorie malnutrition, benign prostatic hyperplasia, dementia with agitation, sleep apnea, repeated falls, gout, atherosclerotic heart disease, hyperparathyroidism, gastroesophageal reflux, post-traumatic stress disorder, AFIB (irregular heartbeat), congestive heart failure, cardiomyopathy, hypertension, and hyperlipidemia.R1's MDS (Minimum Data Set) dated September 23, 2025, shows R1 is cognitively impaired and requires extensive assistance of one staff member for activities of daily living tasks.On October 14, 2025 at 11:04AM V14 (Family Member) said R1 was left soiled for prolonged periods of time, and on September 25, 2025, they complained R1 had feces on his arms, hands, and under his fingernails and was not properly cleaned. V14 said that staff failed to promptly provide hygiene assistance for R1. V14 said that she informed the nurse and aide on duty as well as administrator at the time of this occurred.Review of grievances obtained on October 14, 2025, did not notate occurrence.2. R4 is a [AGE] year-old male who was admitted to facility on March 10, 2025.R4s face sheet includes the following diagnoses: Osteoarthritis, benign prostatic hyperplasia, bilateral knee stiffness, frequent falls, cardiac murmur, abnormal gait, and spondylosis.R5s current care plan dated August 15, 2025, shows a potential for skin integrity impairment due to incontinence of bowel and bladder and requires staff assistance for incontinence care.R5's MDS (Minimum Data Set) section C dated August 15, 2025 shows R4 is cognitively intact.On October 14, 2025 at 11:17 AM, R4 was lying in bed alert and oriented, wearing a hospital gown and watching television. R4's bed sheet and transfer pad had a large dark yellow ring on their surface, and a foul odor was present in the room. R4 said he had not been changed since the previous night and no aide had been in yet that morning. A green bag filled with soiled linen and a clear white bag containing soiled briefs were lying on the floor near the bed.On October 14, 2025 at 11:20 AM, V3(Certified Nurse Assistant) and V4(Certified Nurse Assistant) entered R4's room to provide care. V3 stated that this was her first time doing rounds on the unit and that she had not changed R4 during her shift, and assumed R4 was last changed around 5:00 AM by the overnight shift. V4 stated rounds are typically completed after breakfast and that if no one is available, CNAs (Certified Nursing Assistant) proceed to other duties such as showers.3. R5 is an [AGE] year-old female who was admitted to facility on May 04, 2021.R5's face sheet includes the following diagnoses: depression, insomnia, bilateral cataracts, presbyopia, protein calorie malnutrition, hypertension, falls, and osteoarthritis.R5's current care plan dated July 2025 shows R5 is at risk for impaired skin integrity due to incontinence. Clothes, linen, and adult brief are to be changed promptly when wet. R5's toileting care plan dated June 06, 2021, shows that R5 requires the assistance of one to two staff members for incontinence care and toileting needs.On October 14, 2025 at 11:50 AM, R5 stated that during the day shift on October 13, 2025, she had to wait approximately six hours before being changed. R5 stated she was soiled with feces and had informed her assigned CNA (Certified Nursing Assistant), who never returned, and she was ultimately changed by the evening CNA. R5 reported that she had not yet been checked or changed by the day shift and had last received care from the overnight shift at 5:00 AM. R5 reported that she needed to be changed. 4. R6 is an [AGE] year-old female who was admitted to facility on December 12, 2021. R6's face sheet includes the following diagnoses: atrial fibrillation, anxiety, overactive bladder, anemia, hypothyroidism, hypertension, and congestive heart failure. R6's current care plan dated February 10, 2024, shows a risk for skin impairment with a need for staff assistance for incontinence care. On October 14, 2025 at 12:10 PM, R6 was in bed with a meal tray next to her and a foul odor was present in her room. V3 (Certified Nursing Assistant) provided care and discovered that R6's adult brief was saturated with urine and feces. V3 said R6 had not been checked or changed prior to meals and that this was her first round of the day. V3 said she believed R6 was last changed around 5:00 AM by the overnight CNA. On October 15, 2025 at 1:11 PM, V6 (Certified Nursing Assistant) stated she was not present during the incident with R1 but confirmed that facility protocol requires residents to be checked and changed every two hours and before and after meals.On October 15, 2025 at 2:15 PM, V2 (Director of Nursing) stated that CNAs are expected to