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	04/13/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision to residents at high risk for falls due to poor cognition, poor safety awareness, impulsiveness, and a history of repeated falls. This failure applies to one of three residents (R4) reviewed for accidents and supervision and resulted in R4 sustaining multiple fractures. Findings include:R4's EMR (Electronic Medical Record) showed R4 was admitted to the facility on [DATE]. R4 is currently [AGE] years old and has diagnoses that include vitamin D deficiency, altered mental status, mixed incontinence dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R4's care plan showed R4 was at high risk for falls related to a history of falls, dementia, behavior with psychotic disturbance, anxiety, altered mental status, incontinence and medication use. The interventions included use of a bed alarm when in bed, use of a chair alarm when up in wheelchair, non-skid pad to minimize risk of sliding out of chair and encourage R4 to participate in daily activities to minimize potential for falls while providing diversion and distraction. On April 13, 2026, at 12:35 PM, V5 (Registered Nurse) said on February 13, 2026, she was giving medication to another resident in the common area of the 3rd floor. V5 said she heard a commotion in the dining room and when she responded she saw R4 on the floor in the dining room in front of her wheelchair on her hands and knees. On April 13, 2026, at 12:45 PM, V2 (Director of Nursing) said R4 self-propels herself around the unit non-stop and staff can hardly keep up with her. V2 said the staff are to redirect R4 to sit back down when they see her attempting to get up on her own. On February 13, 2026, when R4 fell, she stood up too quickly from her chair and the staff could not reach her before she fell. V2 said R4 is very impulsive. R4's incident report dated February 13, 2026, at 7:15 PM, showed R4 was self-propelling around the unit and at 7:50 PM, R4 had an unwitnessed fall. R4 had gotten up from her wheelchair, lost her balance and fell, she was found on the floor in front of the wheelchair and was observed with a nosebleed. R4 was sent to the hospital for further evaluation and returned to the facility from the hospital with a diagnosis of a closed nasal bone fracture. R4's EMR (Electronic Medical Record) showed on March 28, 2026, at 9:02 AM, R4 had an unwitnessed fall. R4 was found sitting on the floor in her room at the foot of her bed. R4 had some swelling around her left eye and was complaining about pain in her left wrist. She was sent to the hospital and diagnosed with a left wrist fracture. R4's post fall investigation dated March 30, 2026, showed the root cause analysis factors that may have contributed to R4's fall included R4 getting up on her own and poor safety awareness. There was no mention of the bed alarm alerting staff that R4 had gotten out of bed. On April 09, 2026, at 12:52 PM, V9 (Certified Nursing Assistant) said the overnight staff will normally get R4 up, dressed, and in her wheelchair upon waking, but on March 28, 2026, R4 was still in bed. After R4 had finished eating breakfast, V9 said she was going to provide R4 with morning care to get her cleaned up, dressed, and up into her wheelchair. V9 said R4 prefers pullups but she didn't have any on her cart, so V9 said she went to the linen room to get one. V9 said R4 has a habit of getting up out of her bed or wheelchair chair unassisted, and on this day, V9 said it was less than a minute from when she left R4's room to get a pull up to the time she returned to R4's room. When she returned to R4's (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	room, R4 was already on the floor right in front of the foot of her bed. V9 said R4's bed alarm was activated when she fell and could be heard at the nurse's station, The other aides were assisting other residents, and V7 (Registered Nurse) was on the phone at the nurse's station during this incident. V9 said you cannot see inside R4's room or see R4's bed from the nurse's station. V9 said she has worked with R4 for approximately six months and R4 has never used her call light and has always attempted to self-transfer without assistance. V9 said R4 frequently tries to stand up out of her chair and at times will attempt to walk saying she's packed up her belongings and is checking out of the facility. V9 said fall interventions for R4 include keeping an eye on R4 and redirecting her. V9 said monitoring R4 includes rounding and looking for R4 if you haven't seen her in 10 minutes, and all staff are responsible for monitoring the residents on the floor. On April 09, 2026, at 1:33 PM, V7 (Registered Nurse) said on March 28, 2026, they had just completed clearing breakfast trays, and she was passing her morning medications to the residents when an aide told her R4 was on the floor. V7 said R4 was sitting flat on her butt in front of the bed and had a bump on her head. V7 said R4 doesn't use her call light due to dementia and hasn't been since she's known her for at least two years. V7 said R4 frequently attempts to get up unassisted and has almost no safety awareness, R4's room cannot be seen from the nurse's station, and it's a big challenge to keep an eye on R4. R4 is moody and combative. V7 said R4 constantly wanders, and it is not good for R4 to be in her room when she's up. On April 09, 2026, at 3:59 PM, V2 (Director of Nursing) said R4 has a high probability of getting up on her own. If R4 refused to get up out of bed on March 28, 2026, when staff attempted to get her up, V2 said she would suggest staff stay with R4 until she's ready to get up. V2 said staff should always be aware of R4's whereabouts. V2 said on the day of this fall (March 28, 2026) R4 initially didn't want to get up so staff decided to let her eat breakfast in bed. The facility's policy regarding Routine Resident Checks, showed Nursing staff will make structured and regularly scheduled routine resident checks to help proactively maintain resident safety and wellbeing.To promote resident safety and wellbeing of our residents, nursing staff shall make a routine resident check on each unit at least every 2 hours and/or as often as needed concordant to the resident's needs. Rounding Tips; Individualized Care - tailor rounds to the specific needs of each patient.