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	09/06/2024

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

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on observation, interview and record review, the facility failed to request a re-evaluation for a PASARR II (Pre-admission Screening and Resident Review) screening for a resident with an SMI (serious mental illness) diagnosis within the required timeframe. This applies to 1 of 1 resident (R96) reviewed for PASARR in the sample of 24. The findings include: R96's EMR (Electronic Medical Record) showed R96 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder and major depressive disorder. R96's MDS (Minimum Data Set) dated July 16, 2024 showed R96 had severe cognitive impairment. R96's care plan showed R96's bipolar diagnosis and signs and symptoms of depression caused the resident to have little interest in doing activities and has a self care performance deficit for ADLs (activities of daily living). R96's PASARR Level I was done on May 14, 2024. The PASARR I rationale showed a 60 day convalescent care approval - A 60 day or less stay in the nursing facility was authorized. Re-screening must occur by or before the 60th day if the individual is expected to remain in the NF (nursing facility) beyond the authorization on timeframe. R96 was due for a re-screen on July 15, 2024, making his re-evaluation seven weeks overdue. On September 4, 2024, at 9:02 AM, V1 (Administrator) provided a copy of PASARR I when she was asked about a PASARR II, V1 said the PASARR I did not indicate R96 needed a PASARR II. V1 said V14 (Admissions Director) is responsible for PASARRs. On September 4, 2024, at 11:07 AM, V14 (Admission Director) said when a resident is being admitted from the local hospital, she will log into (Electroninc web-based platform) system for the (Service Company) report PASARR (Preadmission Screening and Resident Review). V14 said she will review and upload the report into the EMR (Electronic Medical Record). Sometimes it will say the resident needs a PASARR II and sometimes it will say they do not have to have a PASARR II. If it says it is approved for 30 days or 60 days, it is because the resident is coming here for short term rehab and they may not need to have the PASARR II done. If the resident needs to stay in the facility longer than either the 30 days or 60 days on the PASARR I, then we need to do a PASARR II. (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
	145307	A. Building B. Wing	09/06/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided their policy titled, PASARR Screening of Residents with Mental Disorders or Intellectual Disability with a revision date of August 16, 2024, showed, Policy is to ensure residents with a Mental Disorder and those with Intellectual Disorder will receive a PASARR Screening within the timeframe allowed.

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	145307	A. Building B. Wing	09/06/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview and record review, the facility failed to assist residents identified as needing assistance with personal hygiene and grooming. This applies to 7 of 7 residents (R19, R26, R30, R57, R71, R97 and R259) reviewed for ADLs (activities of daily living) in the sample of 24. The findings include: 1. R19 had multiple diagnoses including hemiplegia affecting left nondominant side, based on the face sheet. R19's quarterly MDS (minimum data set) dated August 17, 2024 showed that the resident was moderately impaired with cognition and required assistance from the staff with personal hygiene. On September 3, 2024 at 10:45 AM, R19 sitting in her bed, alert and verbally responsive. R19 had left sided weakness and was not able to open or extend the fingers on her left hand. R19 can only open and extend her right thumb and index finger while the rest of her right fingers were contracted. R19's fingernails were long, jagged and with black substances underneath the nails. The long fingernails on R19's left hand were touching the palm area. R19 stated that she wanted the staff to trim and clean her fingernails. On September 4, 2024 at 11:48 AM, R19's fingernails were long, jagged and with black substances underneath the nails. R19 was not able to open or extend the fingers on her left hand. The long fingernails on R19's left hand were touching the palm area. R19 stated that she wanted the staff to trim and clean her fingernails. V2 (Director of Nursing) was present during the observation and stated that R19 cannot trim and/or clean her own fingernails. According to V2, R19 needs the assistance of the staff with ADLs including cleaning and trimming of fingernails. R19's active care plan initiated on May 16, 2023 showed that the resident have ADL self-care performance deficit. The same care plan showed multiple interventions including extensive assistance from the staff with personal hygiene. 2. R26 had multiple diagnoses including sudden visual loss of the left eye and dementia without behavioral disturbance, based on the face sheet. R26's quarterly MDS dated [DATE] showed that the resident was severely impaired with cognition and required assistance from the staff with personal hygiene. On September 3, 2024 at 12:19 PM, R26 was sitting in her wheelchair inside the unit dining room with other residents and staff. R26 was alert and verbally responsive. R26 had accumulation of long, curling chin hair and she was observed playing/pulling it. R26 stated, I am hoping for the staff to shave me. (continued on next page)

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	145307	A. Building B. Wing	09/06/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On September 4, 2024 at 11:57 AM, R26 was in bed, alert and verbally responsive. R26 had accumulation of long, curling chin hair. In the presence of V2, R26 stated that she wanted the staff to shave her chin hair. According to V2, R26 needs the staff assistance with shaving. R26's active care plan initiated on February 1, 2024 showed that the resident have an ADL self-care performance deficit. The same care plan showed multiple interventions including maximum assistance from the staff with personal hygiene. 3. R57 had multiple diagnoses including vascular dementia with other behavioral disturbance, based on the face sheet. R57's MDS dated [DATE] showed that the resident was moderately impaired with cognition and required assistance from the staff with personal hygiene. On September 3, 2024 at 12:02 PM, R57 was sitting in his wheelchair at the hallway outside his room. R57 had accumulation of long facial hair. R57 stated that he needs the assistance of the staff to shave. On September 4, 2024 at 11:52, R57 was inside the unit dining room. R57 had accumulation of long facial hair. V2 was present during the observation and stated that R57's facial were long and that the resident needed the assistance of the staff to shave. R57's active care plan initiated on May 30, 2024 showed that the resident had ADL self-care performance deficit. The same care plan showed interventions including extensive assistance from the staff with personal hygiene. 4. R71 had multiple diagnoses including dementia with other behavioral disturbance and dementia with psychotic disturbance, based on the face sheet. R71's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognition and required maximum assistance from the staff with dressing and personal hygiene. On September 3, 2024 at 12:13 PM, R71 was sitting in his wheelchair inside the unit dining room with other residents. R71 was alert and verbally responsive. R71 had accumulation of long facial hair and his gray shirt had lots of dried white flaky substances on the neck, shoulder, back and chest area. R71 stated that he wanted the staff to change his shirt and to shave him. V8 (Registered Nurse) was present during the observation. According to V8, R71 needs the staff assistance to shave and change his clothing. R71's active care plan initiated on January 10, 2023 showed that the resident have an ADL self-care performance deficit. The same care plan showed multiple interventions including extensive assistance from the staff with personal hygiene. 5. R97 had multiple diagnoses including cerebral infarction due to unspecified occlusion or stenosis of the left posterior cerebral artery, metabolic encephalopathy and type 2 diabetes mellitus, based on the face sheet. (continued on next page)

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	145307	A. Building B. Wing	09/06/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R97's admission MDS dated [DATE] showed that the resident was severely impaired with cognition and required assistance from the staff with personal hygiene. On September 3, 2024 at 11:03 AM, R97 was sitting by the side of her bed. R97 was alert and verbally responsive. R97's fingernails were long, jagged with black substances underneath the nails. According to R97, it has been a long time since her fingernails were trimmed and cleaned and she wanted the staff to do it. On September 4, 2024 at 11:54 AM, R97's fingernails were long, jagged with black substances underneath the nails. R97 stated that she wanted the staff to at least file and clean her fingernails. V2 was present during the observation and stated that R97 needs the staff assistance to trim or file and clean her fingernails. R97's active care plan initiated on May 28, 2024 showed that the resident have an ADL self-care performance deficit. The same care plan showed multiple interventions including extensive assistance from the staff with personal hygiene. On September 4, 2024 at 12:00 PM, V2 (Director of Nursing) stated that providing ADL assistance to resident's including shaving/removing of unwanted facial hair and trimming and cleaning of fingernails are part of the facility's nursing care and service to ensure that the resident's personal hygiene and grooming are maintained. 29562 6. Face sheet shows R30 is [AGE] years old who has multiple medical diagnoses which include Alzheimer's disease and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R30's MDS shows that R30 requires assistance with hygiene and grooming. On September 4, 2024, at 11:35 AM, R30 was resting in bed, alert and oriented, she was able to verbalize her needs. R30 displayed overgrown hair in the chin which was thick and curly, and she has long fingernails with black/brown substances underneath the nails. R30 stated she knows she needs shaving and her nails to be clipped and she wants it done. R30's active ADL care plan shows; R30 have an ADL self-care performance deficit and impaired mobility related to recent fall, encephalopathy, unsteady gait. The same care plan shows multiple interventions which include R30 requiring extensive assistance with personal hygiene care. 36567 7. R259's EMR (Electronic Medical Records) showed that she was admitted on [DATE] with diagnoses including Parkinson's disease with dyskinesia, without mention of fluctuations, essential tremor, anxiety disorder, unspecified. Physician progress notes dated September 2, 2024 included that R259 has mobility and ADL dysfunction secondary to sepsis, acute kidney injury, hypernatremia, hypokalemia. The same progress notes documented that R259 needs assistance with personal care. (continued on next page)

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	145307	A. Building B. Wing	09/06/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On September 3, 2024 at 11:42 AM, R259 was seated in her bed in a hospital gown. R259 was noted to have very long nails with some of them jagged and with blackish and brownish substances caked underneath most of the nail beds. R259 was alert and oriented and able to communicate needs. R259 stated I came here 4 days ago. Regarding the nails, R259 stated They can be shortened and cleaned. I don't know if they will do it for me. This information was relayed V8 (Registered Nurse). R259's interim care plan initiated August 30, 2024 included that R259 requires assistance with ADL's including personal hygiene.

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	145307	A. Building B. Wing	09/06/2024

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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** 41855 Based on observation, interview and record review, the facility failed to provide staff supervision during meal times to a resident with difficulty swallowing and staff failed to use a gait belt/transfer belt when assisting and transferring a resident. This applies to 2 of 4 residents (R75 and R98) reviewed for accidents and supervision in the sample of 24. The findings include: 1. R98's EMR (Electronic Medical Record) showed the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism of unspecified cerebral artery and dysphagia (difficulty swallowing). R98's MDS (minimum data set) showed the resident had severe cognitive impairment and required set-up assistance with meals. R98's care plan showed that the resident was at risk for choking or aspiration of food or liquid related to his diagnoses of cerebral vascular accident and dysphagia. R98 was also edentulous. The interventions the facility put in place included to instruct R98 to eat in an upright position, to eat slowly, chew each bite thoroughly, monitor for shortness of breath, labored respirations, or lung congestion. Staff are to observe R98 during mealtimes for signs and symptoms of aspiration such as coughing and throat clearing. R98's POS (physician order sheet) showed an order for mechanical soft texture diet with thin liquids. R98's hospital record for a nutritional assessment dated [DATE] showed the resident had chewing problems and dysphagia. Interventions included mechanical soft diet, aspiration precautions, and 1:1 feeding assistance. R98's Speech Therapy admission evaluation done on August 5, 2024 showed oral phase moderately impaired caused by prolonged mastication, increased transit time, and mild oral residue post-swallow. No pharyngeal symptoms observed; however, due to impaired oral phase [R98] is at risk of aspiration of non-masticated boluses. On September 3, 2024, at 11:55 PM, R98 was in the dining room eating lunch. R98 had mechanical soft chicken, macaroni and cheese, and spinach. Dietary staff were all the way across the dining room closest to the door where staff would come grab room trays to take to the residents in their rooms. Staff were coming and going and no one was monitoring or paying attention to the residents in the dining room. R98 started coughing and staff continued to come and go from the dining room. No one stopped to see if R98 was alright. Surveyor went to R98 and asked if he was ok, he was able to speak and said he's ok. R98 continued to cough. (continued on next page)

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	145307	A. Building B. Wing	09/06/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On September 4, 2024, at 12:00 PM, R98 was in his bed with his lunch tray in front of him on his over the bed tray table. R98 was sitting with the head of bed at a 45 degree angle. R98 started coughing after putting food into his mouth. No staff was in the room with R98. Surveyor asked R98 if he would like to sit up higher in the bed and he shook his head yes. He was eating a ground hamburger steak with mushroom gravy, pureed cream corn, pureed white rice, and orange sherbet. He was drinking juice. At 12:07 PM Surveyor went and asked V15 (Registered Nurse) to get some help to sit R98 up higher in the bed. V15 and V16 (Certified Nursing Assistant) went to R98's room and together they pulled R98 up in the bed and raised the head of the bed up so that he was sitting at a 90 degree angle. V15 said R98 should be sitting upright (90 degrees) to prevent aspiration. He has aspiration precautions in place. V15 asked V16 to watch R98 until he was done eating. On September 5, 2024 at 3:37 PM, V2 (Director of Nursing) said the residents in the dining rooms are to be monitored at all times for choking. On September 5, 2024, at 9:25 AM, V18 (Speech Therapist) said when R98 came to this facility she reviewed his chart and noted that R98 was on a mechanical soft diet. V18 said she observed R98 eating his mechanical soft diet with thin liquids and he tolerated it well. V18 said R98 had a stroke and he has dysphagia so he requires general aspiration precautions which include sitting upright and taking small bites at a time. V18 said she observed him this morning and he was in bed reclined at about a 45 degree angle. V18 said she had him attempt to eat regular solid food and he did cough, but cleared after he was offered some liquid to drink. V18 said that R98 should not be in a reclining position when eating and staff should be aware of that. 16746 2. R75 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and dementia without behavioral disturbance, based on the face sheet. R75's significant change status MDS dated [DATE] showed that the resident was severely impaired with cognition. The MDS showed that R75 required moderate assistance from the staff with toileting hygiene, lower body dressing and from sitting to standing position. The same MDS showed that R75's ability to toilet transfer, including getting on and off a toilet or commode was not attempted due to medical condition or safety concerns. (continued on next page)

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	145307	A. Building B. Wing	09/06/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On September 3, 2024 at 12:25 PM, R75 was observed sitting on the toilet while V17 (Certified Nursing Assistant) was by the bathroom door. After R75 finished using the toilet, V17 held on to R75's left arm and asked the resident to stand and hold on to the grab bar that was attached on the wall, located on the right side of the resident, to clean R75's back area. R75 stood up and attempted to hold on to the grab bar using only his right hand. R75 was confused and V17 had to give the resident several instructions to hold on to the grab bar with both hands. When R75 was finally able to stand while holding on to the grab bar with both hands, V17 started cleaning R75's buttocks. While R75 was standing and V17 was cleaning the resident, R75's legs were observed to be slightly bent from the knee and his legs were slightly shaking. After V17 had cleaned R75, V17 assisted the resident to transfer and sit on his wheelchair. During the observation no gait belt or transfer belt was observed being used to assist R75, to stand and to transfer. After the procedure, V17 was asked if she has a gait belt/transfer belt with her and if she used it to transfer R75 from his wheelchair to the toilet. V17 responded that she does not have a gait belt/transfer belt with her and that she did not use a gait belt/transfer belt to transfer R75. V17 acknowledged that a gait belt/transfer belt will be useful to transfer and assist R75 to prevent fall incident and for resident's safety. R75's medical records showed that the resident had a history of fall with injury, when he stood up from his wheelchair, attempted to walk and lost his balance. R75's active fall care plan initiated on February 10, 2024 showed that the resident was at risk for fall related to recent fall, cardiovascular accident, unsteady gait and psychotic disturbance. On September 4, 2024 at 11:33 AM, V2 (Director of Nursing) stated that a gait belt/transfer belt should always be used when manually assisting a resident to transfer from bed to wheelchair and back, from wheelchair to toilet and vice-versa. V2 added that a gait belt/transfer belt should always be used when assisting any resident to stand, pivot and while a resident is standing even if the resident is holding on a grab bar, to ensure resident's safety and to prevent accidents including fall. The facility's gait belt policy and procedure last revised by the facility on July 26, 2024 showed. The facility will use gait or transfer belts to assist residents needing limited to total assistance during transfers and walking.

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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. 29562 Based on observation, interview, and record review, the facility failed to provide perineum and indwelling urinary catheter care in a manner that would prevent urinary tract infection. This applies to 4 of 6 residents (R15, R30, R65, R85) reviewed for perineum and urinary catheter care in the sample of 24. The findings include: 1. On September 4, 2024 at 9:45 AM, R85 was resting in bed, she has an indwelling urinary catheter. V4 and V5 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R85 who had a bowel movement. V4 cleaned R85 from front to back of the perineum, however, V4 did not separate labia to clean the inner corners and the catheter right outside the urethra. 2. On September 4, 2024 at 11:39 AM, V6 (CNA) rendered incontinence care to R30 who was heavily saturated with urine and had a bowel movement. There was a strong urine odor coming from resident's bedroom. V6 used a wet washcloth to clean R30's perineum and wiped it in an up and down stroke on the outer labia. V6 did not open the labia to clean the inner corners, the urethra, and the inner groins. 3. On September 4, 2024 around 2:15 PM, V6 rendered incontinence care to R15 who was wet with urine. V6 used a wet washcloth to wipe the outer labia in an up and down stroke. V6 took another washcloth to clean the labia and wipe it again in an upward stroke. V6 did not separate the labia to clean the inner corners, and the inner groins. 4. On September 5, 2024, at 1:26 PM, V19 (Restorative CNA) rendered peri-care to R65 who had a bowel movement. R65 has a suprapubic catheter. R65 has redness all over the front and back perineum. Used a washcloth to clean V19's perineum from front to back. However, V19 did not clean the left side of the abdominal fold, penis, scrotum, and the inner folds of his groins. On September 5, 2024, at 1:51 PM, V3 (Assistant Director of Nursing) stated that when providing peri-care, the staff must clean the full perineum from front to back, which includes the folds of the genitals, pubic area, abdomen, and groins. If it is a female resident the staff should separate the labia to clean the inner corners of this area. If it is a male, this includes the penis and scrotum. This is needed to be done to prevent infection. Facility's Incontinent and Perineal Care Policy and Procedure with revised date of 7/31/24 shows: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition.

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	145307	A. Building B. Wing	09/06/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 36567 Based on observation, interview and record review, the facility failed to prepare pureed consistency hamburger beef steaks to residents on pureed diet. This applies 6 of 6 residents (R1, R4, R24, R25, R50, R319) reviewed for pureed diets in the sample of 24. The findings include: On September 04, 2024 at 10:01 AM, during pureed meal preparation of pureed hamburger steak in the facility kitchen, V13 (Cook) stated that he is preparing for 6 residents. V13 measured six portions (about 3 oz/portion) of cooked hamburger beef steaks into the blender and added about 1 oz of beef broth and blended the product. The final product appeared granular and V13 transferred the pureed mixture into a container and stated that he is going to reheat the mixture prior to service. When the pureed meat was taste tested , there was granules of meat and fat that had to be chewed. V10 (Regional Director of Operations), who was in the vicinity was notified that the product was not safe to serve with current granular consistency. V10 also taste tested the pureed meat and agreed that its granular and instructed V13 to blend it again with an extra ounce of fluid. When blended again, the final product was smooth without any granules. On September 04, 2024 at 10:29 AM, V10 stated that the pureed consistency should be very smooth on the tongue with no textures detected and should not have any grinds. Facility policy titled Pureed included as follows: Description: This diet consists of pureed, homogeneous, and cohesive foods. Food should be pudding-like No coarse textures . Any foods that require bolus formation, controlled manipulation, or mastication are excluded. Facility diet order report showed that R1, R4, R24, R25, R50 and R319 were on pureed consistency diets.

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	145307	A. Building B. Wing	09/06/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36567 Based on observations, interview and record review, the facility failed to maintain sanitizer in dish machine during dish washing and failed to ensure that cold foods are stored properly per facility policy guidelines. This applies to 114 residents who receives meals prepared in the facility kitchen. The findings include: Facility provided information that the census on September 3, 2024 was 116 residents with 2 (two) residents on NPO (nothing by mouth) status. On September 03, 2024 at 9:49 AM, V11 (Dietary Aide) was washing dishes at the dirty side of the low temperature dish machine and stacking the dirty dishes on racks to pass through the dish machine. Some newly washed dishes that were placed on racks were seen on the clean side of the dish machine. On request, since V11's hands were soiled, V10 (Regional Director of Operations) tested the sanitizer well with a chlorine test strip and the test strip remained white color. V10 tested it again, and the test strip remained white color. V11 pointed to the sanitizer container on the floor which was connected to the dish machine, and which was nearly empty and stated that the test strip was probably not testing because the sanitizer is running low. When asked when she last tested the sanitizer, V11 stated that she usually tests it before starting the process of washing the dishes after breakfast and that she had tested the sanitizer at 9:00 AM. V11 stated that she does not test it again in between washing/sanitizing the breakfast dishes. V11 stated that she would test the sanitizer again before washing the lunch dishes as that is how it's marked on the log. The Low temperature Dish machine Sanitizer Log showed that on September 9, 2024 at 9:00 AM, the concentration (of sanitizer) was 100 ppm (parts per million). In the reach in freezer, spills of unknown substances were noted on bottom of a free-standing reach in freezer. There was a 3-gallon tub of strawberry flavored ice cream with a broken lid which was loosely placed over the tub and not closed properly. More than half of the ice cream in the container was used. V10 stated that the ice cream is served as a preference to residents that request for the same. V10 added that the ice cream container should have been closed properly. (continued on next page)

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	09/06/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On September 04, 2024 at 10:21 AM, V12 (Dietary Aide) was at the dish machine washing dishes at the dirty side of the low temperature dish machine. At the clean side of the dish machine there were two racks of trays and one rack of cups that were just washed through the dish machine. V12 stated that she had already tested the sanitizer in the morning prior to washing the dishes and it tested okay. V12 was asked to test it again for verification and V12 hesitated and stated that the chlorine stopped coming out of the nozzle and that she will have to wait for it to come out. After 2-3 minutes of continuing to run the machine, V12 was asked again to test the sanitizer in the sanitizer well and when tested , the test strip showed white color. V10 came to the area and tinkered with the sanitizer container on the floor and the supply piping and V12 tested the sanitizer again and it showed a purple color registering between 50-100 ppm. V10 stated that she will notify the maintenance as the chlorine should be readily dispensing during sanitation process. V10 was notified that the earlier seen racks of washed dishes will have to be re-send through the dish machine to ensure that they are properly sanitized. Facility Policy titled Ware Washing (dated October 2019) included as follows: Policy Statement: It is the center policy that all dishware and service ware will be cleaned and sanitized after each use. The same policy showed, Low-Temperature Dish machine Sanitizer Log guidance (Dated May 29, 2024) included as follows: Chlorine concentration must be between 50-100 ppm. Facility policy titled Food Storage: Cold (dated October 2019) included as follows: Policy Statement: It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of FDA (Food and Drug Administration) Food Code. The same policy showed, 5. The Dining Service Director/Cook(s) insures that all food items are stored properly in covered containers .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 29562 Based on observation, interview, and record review, the facility failed to follow standard infection control practices during provisions of incontinence and catheter care related to hand hygiene and gloving. The facility also failed to sanitize glucometer machine during blood glucose monitoring. This applies to 6 of 24 residents (R9, R15, R30, R65, R85, R105) reviewed for infection control in the sample of 24. The findings include: 1. On September 4, 2024, at 9:45 AM, V4 and V5 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R85 who had a bowel movement. V4 cleaned from front to back, applied incontinence brief, help straightened R85's clothing, and help with repositioning, while wearing same gloves, and did not perform hand hygiene in between tasks. 2. On September 4, 2024, between 11:22 AM to 11:30 AM, V7 (Nurse) checked R9 and R105's blood glucose level. V7 did not sanitized the glucometer machine prior to usage, and in between use of R9 and R105. After V7 used the glucometer, he placed it back in the medication cart without cleaning or sanitizing it. 3. On September 4, 2024, at 11:39 AM, V6 (CNA) rendered incontinence care to R30 who was heavily saturated with urine and had a bowel movement. V6 cleaned R30 from front to back of the perineum, while wearing same gloves she touched the curtain, then she continued to clean the buttocks. V6 removed her gloves and without hand hygiene, went to get more wet washcloths. V6 came back, donned new set of gloves and continued to clean the rectal and buttocks area of R30. After she completed the peri-care, V6 placed a new incontinence brief and put a set of clean pants on R30 and helped reposition R30 while wearing same soiled gloves. 4. On September 4, 2024, around 2:15 PM, V4 and V6 (Both CNA) rendered incontinence care to R15 who was wet with urine. V6 cleaned R15's perineum from front to back, applied new incontinence brief, helped assisted with R15's repositioning, and covered R15 with clean blanket while wearing same soiled gloves. 5. On September 5, 2024, at 1:26 PM, V19 (Restorative/CNA) rendered peri-care to R65 who had a bowel movement. V19 cleaned R65 from front to back of the perineum. V19 changed his gloves without hand hygiene, then he continued to clean R65's rectum and buttocks. While wearing the same gloves, V19 applied barrier cream to the back perineum, followed by placing a clean incontinence brief on R65. On September 5, 2024, at 1:48 PM, V3 (Assistant Director of Nursing) stated that staff must wash their hands prior to peri-care, don gloves, and proceed with the peri-care. The staff should change gloves and perform hand hygiene from dirty to clean tasks. In addition, V3 said, staff must sanitize the glucometer machine before and after use, and in between residents. These are to be done to prevent spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Hand Hygiene Policy and Procedure with a revision date of July 30, 2024, showed, Policy Statement: Hand hygiene is important in controlling infections. hand hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC Guidelines regarding hand hygiene. The same policy showed in-part under procedures, 1. Hand Hygiene using alcohol-based hand rub is recommended during the following situations: . g. Before moving from work on soiled body site to a clean body site on the same resident, h. After contact with blood, body fluids, or surfaces contaminated with blood and body fluids, i. After removing gloves including during wound dressing change. Facility's Glucose Meter Cleaning Policy and Procedure with revision date of 7/30/24 shows: Policy Statement: To ensure safe, convenient, and proper cleaning and disinfection of Blood Glucose Meters in accordance with CDC guidelines and manufacturer's instructions to help prevent device exposure to blood borne pathogens. The same policy showed in-part under procedures, 4. Clean and disinfect glucose meter with EPA-approved disinfectant including Clorox Healthcare Bleach Germicidal Wipes/ Micro kill Wipes/ Microdot Wipes/ Avert Wipes before after each resident use. 6. Always clean and disinfect the glucose meter before storing it with other clean equipment.