STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145339	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Elmhurst, The	127 West Diversey Elmhurst, IL 60126

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 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** 39543 Based on observation, interview, and record review the facility failed to assess and treat a wound when it was first identified. This applies to 1 (R1) of 3 residents reviewed for wound care in the sample of 3. The findings include: R1's Admission Record (Face Sheet) showed an admitted [DATE]. The Face Sheet showed diagnoses to include but not limited to Alzheimer's, Pressure ulcer, contractures of the legs, failure to thrive, and palliative care. R1's Admission Minimum Data Set (MDS) from 11/26/24 showed he had short and long-term memory loss. The MDS showed he had limited range of motion in all extremities. The MDS showed R1 was dependent upon staff for every activity of daily living to include oral care, feeding, toileting hygiene, dressing, and personal hygiene. On 1/13/25 at 11:36 AM, V11 (R1's family) addressed an email to the state health department. The email showed, V11 was at the facility on 1/7/25, she was in R1's room during incontinence care, and she noted a wound to R1's scrotum that she was not previously aware of. On 1/16/25 at 10:00 AM, V4 (Wound Care Director) began providing wound care for R1 while (V7 Wound Care Nurse Practitioner) assessed R1's wounds. At the request of the state surveyor, R1's perineal area was assessed, and a quarter sized wound was observed to R1's scrotum. The wound was not draining and was superficial. R1 has black skin tone, and the wound was bright pink. V4 and V7 both stated they were not aware of the wound. V7 provided an order for a petroleum type jelly for protection. V7 stated she would also request an order from hospice for a catheter to promote healing of this wound as well as his other wounds. On 1/16/25 at 11:00 AM, V5 (Certified Nursing Assistant-CNA) stated she reported R1's scrotum wound weeks ago. V5 stated it was also documented in R1's Electronic Health Record (EHR). V5 demonstrated where she would document skin alterations. R1's Shower/Bathing and Skin Monitoring charting from 11/15/24 through 1/16/25 showed no documented skin alterations. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 12:06 PM, V5 was informed there were no documented skin alterations to R1's scrotum. V5 was not able to explain this; however, she reiterated R1's scrotum wound had been reported and the wound had been there for several days. On 1/16/25 at 12:45 PM, V11 stated she was at the facility on 1/7/25. V11 stated R1 had a bowel movement, and she requested the staff provide incontinence care. V11 stated, during the incontinence care, she noted the wound to R1's scrotum and requested staff apply an ointment. On 1/16/25 at 1:15 PM, V4 (Wound Care Director) stated he was not aware of R1's scrotum wound. V4 stated either herself or her wound care staff should have been notified of the scrotal wound when it was first found. V4 stated the importance of notification is so assessment and treatments can be initiated. V4 stated the assessment provides a baseline of the wound for tracking and it also dictates the treatments that will be applied. V4 stated treatments are important to prevent infection and promote healing. R1's 1/16/25 wound assessment (Authored by V7 Nurse Practitioner) identified the wound as moisture associated skin damage (MASD) and was 3.0 cm (centimeters) by 1.5 cm. The facility's wound report, provided on 1/16/25 at 11:00 AM, showed no documented wounds to R1's scrotum. R1' Treatment Administration Record (TAR) from 1/16/25 at 11:46 AM, showed no treatments were in place for R1's scrotum. The facility's Wound Care Guideline policy (Revised 1/24/24) showed, .The resident's skin alteration/breakdown shall be documented in the resident's clinical records in accordance with the facility's policy and in compliance to current regulatory standards .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39543 Based on observation, interview, and record review the facility failed to handle soiled cleaning supplies and soiled bedding in a manner to prevent cross-contamination. This applies to 1 (R1) of 3 residents reviewed for incontinence care in the sample of 3. The findings include: On 1/16/25 at 9:20 AM, R1's room had an odor of feces. V5 (CNA-Certified Nursing Assistant) was providing incontinence care for R1. V5 stated R1 had a bowel movement, and she was cleaning him up. V5 had placed R1's soiled bedding on the floor and she had placed a stool covered washcloth on the bedside nightstand. R1 also had a name band on to his left wrist. The name band had a brown smear that appeared to be stool. V5 did not remove the name band. On 1/16/25 at 1:04 PM, V9 (Licensed Practical Nurse-LPN) stated the substance on the name band appeared to be feces. V9 stated the purpose of the name band is for identifying residents on the memory care unit. On 1/16/25 at 12:45 PM, V11 (R1's Family) stated she had visited R1 on 1/15/25. V11 stated R1's hands were covered in stool, and it also was on his name band. V11 stated it took staff two washcloths to clean his hands. On 1/16/25 at 1:36 PM, V2 (Director of Nursing) stated all incontinence care material, soiled bedding, and soiled items should be placed directly into a plastic bag and not set on the floor or other horizontal surfaces. V2 said this is to prevent cross-contamination. The facility's Incontinent and Perineal Care Policy (revision 7/31/24) showed, 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 .Discard disposable items into designated containers/plastic bag .