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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145339 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Grove of Elmhurst, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p> |

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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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on observation, interview, and record review, the facility failed to provide residents with urinary catheter care. This applies to 6 of 6 residents (R1, R2, R3, R4, R5, and R6) reviewed for urinary catheters. The findings include: 1. On 8/09/2025 at 10:45 AM, R1 was sitting in his wheelchair. R1's urinary catheter tube had amber urine with sediment. R1 said he had recurrent UTIs (urinary tract infections) and was receiving an oral antibiotic. R1 had an open urinary piston syringe with a bottle at bedside. R1 said the nurse would frequently irrigate his catheter because it would get clogged often. R1 said on 8/05/2025 by V11 (Licensed Practical Nurse/LPN) changed his catheter because there was no urine output. R1 said the nursing staff was emptying his catheter but not cleaning it frequently. R1 continued to say that he was dependent on the facility staff to care for his catheter. Then V4 (Certified Nurse Assistant/CNA) came to assess R1's urinary catheter. R1's catheter tube was underneath and over (in an upwards direction) in front of his incontinence brief, not secured. R1's catheter insertion site was soiled with a moderate amount of bowel residue. V4 said she had just provided R1 with catheter care approximately an hour prior. V4 proceeded to adjust R1's tube in a downward direction, and the urine then began to flow into the collection bag. On 8/09/2025 at 12:30 PM, V10 (Registered Nurse/RN) said CNAs were expected to provide routine and as-needed catheter care to prevent infections. V10 also said she was not aware of R1's catheter complications on 8/05/2025. V10 said she reviewed R1's EMR (Electronic Medical Record) and there was no documentation of R1's catheter obstruction complication and need for exchange on 8/05/2025. R1's care plan reviewed on 8/09/2025, said R1 was at risk for UTIs and required an indwelling catheter for obstructive and reflux uropathy. The care plan also said R1 required facility staff assistance with toileting hygiene. R1's interventions included checking catheter tubing for kinks, monitoring and reporting output, and monitoring for signs and symptoms of UTIs. R1's Order Summary Report dated 8/09/2025 did not have orders for routine catheter care, urine output recording, and catheter irrigation procedures. R1's Electronic Medication Administration Record for August 2025 did not show any documentation of R1's catheter exchange procedure. 2. On 8/09/2025 at 11 AM, R2 was in bed. R2's urinary catheter bag with urine inside was hanging from the bed frame without a privacy bag, exposed. R2's urinary catheter tube had light-cloudy amber urine draining. V4 (CNA) said she had just provided R2 with catheter care approximately an hour prior. V4 assessed R2's catheter insertion site, and it had a build-up of yellowish discharge. V4 said she had noticed it prior and would now inform the nurse on duty. R2 said his catheter was being changed monthly by the nurses and was unsure why. R2's care plan reviewed on 8/09/2025, said R2 was at risk for infections and required an indwelling catheter for management of neurogenic bladder. The care plan also said R2 required facility staff assistance with toileting hygiene. R2's interventions included receiving catheter care every shift and as needed, changing foley catheter per facility protocol or MD order, and monitoring output. R2's Order Summary Report dated 8/09/2025 did not have orders for routine catheter care and urine output recording. 3. On 8/09/2025 at 11:20 AM, R3 was in bed. R3's urinary catheter bag with urine inside was hanging from the bed frame without a privacy bag, exposed. R3's urinary catheter tube had thick brown-greenish sediments. R3 said her catheter had been exchanged last week because it was clogged and leaking. R3 said she was also started on a probiotic and cranberry medication because she was having bladder discomfort and vaginal irritation. R3 said her catheter bag was last emptied around 5 AM, and she last had a bowel movement last night. V6 (Registered Nurse/RN) assessed R3's urine and said it was abnormal to have greenish-thick sediment in the urine. V6 said she was not notified prior of R3's abnormal urine and expected to be notified of any abnormal urine color or appearance. V6 said she would change the drainage bag and contact R3's provider for a urine culture. V6 then assessed R3's catheter insertion site. R3's catheter was soiled with bowel residue. R3 said agency CNAs frequently did not provide her proper catheter and incontinence care. V6 proceeded to clean R3's catheter with water, and no soap was added. R3's care plan reviewed on 8/09/2025, said R3 was at risk for UTIs and required an indwelling catheter for management of neuromuscular dysfunction of the bladder. The care plan also said R3 required facility staff assistance with toileting hygiene. R3's interventions included staff to monitor her urine, report any abnormalities for signs and symptoms of UTI, and routine catheter care. R3's Order Summary Report dated 8/09/2025 did not have an order for urine output recording. The report showed a new order dated 8/09/2025 for a urinalysis and culture collection. 4. On 8/09/2025 at 11:30 AM, R4 was in bed. R4 was nonverbal. R4's urinary catheter bag had a scant amount of urine inside and was hanging from the bed frame without a privacy bag, exposed. R4's</p> | | |