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	01/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to respect residents' dignity by using cell phones during resident care. This applies to 3 of 3 resident (R1, R2, and R3) reviewed for resident rights in the sample of 6. The findings include:On 1/7/26 at 10:53 AM, V9 R1's Daughter stated, The CNAs (Certified Nursing Assistants) are on their phones all the time. V9 stated on one occasion she was talking to a CNA, the CNA had earbuds in, the CNA said hold on to the person she was talking to on her cell phone, reached into her pocket to pause the phone call before she could talk to V9. V9 said she has recently observed CNAs on their phone while providing care for her mother. On 1/7/26 at 10:53 AM, R1 stated, regarding staff being on their phones during resident care, I see it all the time. On 1/7/26 at 1:04 PM, V8 R3's Mother stated, I do see staff on their phones all the time. Yes, I have seen staff on their phones when providing care. I don't like it, it shouldn't happen. It is disrespectful. (R3 was nonverbal, not alert, and not oriented.) On 1/7/26 at 12:10 PM, R2 stated she does see staff on their phones while providing resident care. On 1/7/26 at 1:39 PM, V3 Director of Nursing (DON) stated cell phones should not be used while providing care. V3 said it's disrespectful for staff to be on their cell phones while caring for residents. The facility's Proper Cellphone Use policy (reviewed 2/26/21) showed, While at work, employees are expected to exercise discretion in using personal cellphones. Absent extraordinary circumstances or during scheduled employee lunch/breaks, employees are strongly discouraged from making any personal calls or texting during work time.

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: 145339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Grove of Elmhurst, The		STREET ADDRESS, CITY, STATE, ZIP CODE 127 West Diversey Elmhurst, IL 60126	

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to change a resident's feeding tube dressing as ordered. This applies to 1 of 3 residents (R1) reviewed for nursing care in the sample of 6. The findings include:R1's admission Record (Face Sheet) showed she was admitted to the facility on [DATE] with diagnoses to include but not limited to functional quadriplegia (severe disability of all four limbs); ventilator dependence, and heart failure. R1's Order Summary Report (Physician Order Sheet) showed an active order started on 12/4/24 to Cleanse enteral tube feeding site with normal saline and apply dry dressing every night shift. On 1/7/26 at 10:29 AM, R1 was supine in bed feeding herself a sweet roll. There was a foul odor that appeared to be coming from R1. The odor was not consistent with stool odor. On 1/7/26 at 11:30 AM, V15 Shift Coordinator / Certified Nursing Assistant (CNA) and V16 CNA entered R1's room to provide incontinence care. During incontinence care, it was requested that V15 lift R1's hospital gown to expose her abdominal tube feeding site. R1's feeding tube dressing was a typical split 4-inch by 4-inch cotton gauze drainage dressing (A dressing with a slit extending halfway into the dressing so the dressing can encompass the feeding tube.) The dressing near the tube had dried black drainage and the odor which was noted at 10:29 AM became more pronounced. The dressing was dated 12/29 (9 days prior). On 1/7/26 at 11:44 AM, V16 stated the odor was coming from R1's feeding tube site. On 1/7/26 at 11:55 AM, V17 R1's Nurse stated the odor was coming from R1's feeding tube site. V17 stated the date on the dressing is the date the dressing was changed. V17 stated, based on the appearance of the dressing, the date was accurate. V17 stated the dressing should have been changed sometime before 1/7/26. V17 said feeding tube dressings are typically changed daily on the night shift. On 1/7/26 at 12:02 PM, V17 changed R1's dressing. The skin under R1's dressing was reddened and inflamed. V17 stated, R1's skin that was under the dressing appeared raw. R1's December 2025 Treatment Administration Record (TAR) showed R1's tube feeding dressing was documented as being done by the night shift staff on 12/30/25 and 12/31/25. R1's January 2026 TAR showed R1's tube feeding dressing was documented as being done by the night shift staff on 1/1/26 through 1/6/26. On 1/7/26 at 1:39 PM, V3 Director of Nursing stated feeding tube dressings should be changed daily on the night shift. V3 said the purpose of the dressing changes is to prevent infections. V3 said staff should not be documenting the completion of dressing changes unless the dressing change is performed. The facility's Enteral Tube Feeding Care policy (Revised 6/30/25) showed, .Enteral tube stoma care: Site must be cleansed and covered with a dry gauze daily. Dry gauze should be placed on top of the G (gastric/stomach) tube bumper, otherwise, a slim layer of light breathable gauze can be inserted under the disc.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide incontinence care in a manner to prevent urinary tract infections (UTI). This applies to 1 of 3 residents (R1) reviewed for nursing care in the sample of 6. The findings include:R1's admission Record (Face Sheet) showed she was admitted to the facility on [DATE] with diagnoses to include but not limited to functional quadriplegia (severe disability of all four limbs); ventilator dependence, and heart failure. On 1/7/26 at 11:30 AM, V15 Shift Coordinator / Certified Nursing Assistant (CNA) and V16 CNA entered R1's room to provide incontinence care. R1 had a moderate bowel movement that was tar-like. V16 started with R1 being on her back and cleaning the vaginal area. V15 then rolled R1 to her right side and V16 began cleaning R1's buttocks. V16 wiped R1's stool from the top of her buttocks toward her vagina; V16 wiped in this direction twice. V15 spoke quietly and inaudibly to V16 after she had wiped her stool in the direction of R1's vagina. R1 was then rolled onto her back and V16 had to clean her vaginal area a second time. On 1/7/26 at 1:16 PM, V15 stated he was telling V16 to wipe away from R1's vagina. V15 stated wiping the stool the toward the vagina could lead to a urinary tract infection. On 1/7/26 at 1:39 PM, V3 Director of Nursing (DON) stated stool should be wiped away from the vagina to prevent contamination or infection. The facility's Incontinence and Perineal Care policy (revised 6/30/25) 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.Maintain clean techniques.