STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145433	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of St Charles	611 Allen Lane Saint Charles, IL 60174

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ongoing assessment and care planning for residents desiring to self-administer medications.This applies to 2 of 2 residents (R11, R55) reviewed for medications in a sample of 23.The findings include: 1.On 9/23/2025 at 11:16 AM, R11 had Artificial Tears eyedrops, Carboxymethyl Cellulose Sodium Ophthalmic eye drops, Albuterol Sulfate inhaler, and Zoryve (Roflumilast) cream on his bedside table. R11 stated the medications are always kept in his room. He stated no one taught him how to take the medications. R11 stated he knows how to take the medications. R11's MDS (Minimum Data Set) dated 7/2/25 shows that he is cognitively intact R11's POS (Physician Order Sheet) shows an order that R11 may self-administer the Artificial Tears eyedrops and Carboxymethyl Cellulose Sodium Ophthalmic eye drops. There is no order that indicates R11 can self-administer the Albuterol Sulfate inhaler and Zoryve (Roflumilast) cream. Review of R11's electronic medical record indicates there is a self-administration of medication assessment for the Albuterol Sulfate inhaler from 2/16/2021. It says the medication should be stored in the resident's drawer. The medication assessment was not updated after 4 years. There was no self-administration of medication assessment forms for the Artificial Tears eyedrops, Carboxymethyl Cellulose Sodium Ophthalmic eye drops, and Zoryve (Roflumilast) cream. On 9/24/2025 at 3:00 PM, V2 (DON—Director of Nursing) stated there should be an order from the physician to have medications brought from home and to be at the bedside. She also stated that the nurse has to do a self-administration of medication assessment to make sure the resident knows how to take the medication by themselves. V2 stated residents have to demonstrate it in front of the nurse and the assessment is filled out in the resident's electronic medical record. Review of R11's care plans show there are no care plans discussing self-administration of medications. Facility's policy titled Self-Administration of Medication (7/3/25) shows: Procedures: 1. The IDT (Inter-Disciplinary Team) will assign a staff to evaluate resident's ability to safely administer medication. A self-administration evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician order to keep it at bedside. 5. The resident's ability to self-administer medication will be assessed regularly by the facility to coincide with the MDS assessment or any notable change in status. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medication Storage, Labeling, and Disposal policy (rev. 7/2/2025) showed Policy Statement: It is the facility's policy to comply with federal regulations in storage, labeling, and disposal of medications .4. Medications will be secured in locked storage area . The facility's Self-Administration of Medication policy does not include how the medications at bedside should be locked and secured to prevent access by other residents. 2. On 9/23/2025 at 11:00 AM, R55 had a blue inhaler labeled Albuterol and a bottle labeled nasal spray on his bedside table. In an interview at the time, R55 stated: I take it when I think I need it. He further stated that he knows how to use both medications, and that staff allows him to keep them in his room. He reported that he does not recall any nursing staff assessing his ability to use the medications or asking him to demonstrate their usage. R55's MDS dated [DATE] shows that R55 has mildly impaired cognition. R55's Physician's Order Sheet (POS) shows an order for unsupervised self-administration of the albuterol sulfate inhaler as well as orders for fluticasone propionate nasal spray and saline nasal spray, but no orders allowing for unsupervised self-administration of either nasal spray. R55's electronic medical record showed no completed self-administration of medication assessment for any of the medications, and R55's care plan does not show any goals or interventions related to self-administration of medications.

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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** Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) cares for residents who needs assistance.This failure effects to 4 of 4 residents (R12, R13, R22, R44) reviewed for ADLs in a sample of 23.The findings include:1.On 9/23/25 at 11:28 AM, R22 was in bed. His fingernails were long with a black substance underneath his nail tips. He said he told the CNA's (Certified Nursing Assistants) that he would like them cut. He stated, Yeah, it never happened as you can see.R22's face sheet shows diagnoses which include major depressive disorder, single episode, moderate, generalized anxiety disorder, and dementia in other diseases classified elsewhere, mild, with anxiety. R22's MDS (Minimum Data Set) dated 9/4/25 shows he is cognitively intact. R22 needs substantial/maximal assistance with personal hygiene. R22's care plan dated 3/6/25 shows he has an ADL self-care performance deficit and impaired mobility related to .dementia with mild anxiety, major depressing and unsteadiness on feet.2.On 9/23/25 at 10:35 AM, R13 was in bed and had long yellow-colored fingernails. R13 stated he would like them cut.R13's face sheet shows diagnoses of major depressive disorder, dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, bipolar disorder, current episode depressed, moderate, generalized anxiety disorder, and other schizophrenia. R13's MDS dated [DATE] shows he has moderate cognitive impairment. R13 needs substantial/maximal assistance with personal hygiene. R13's care plan dated 11/21/22 shows he has an ADL Self-Care Performance Deficit and Impaired Mobility related to anemia, difficulty walking.schizophrenia, anxiety, depression and dementia with behavioral disturbance.3. On 9/23/25 at 11:52 AM, R12 had a full beard. He stated he wanted to be shaved. He said he has told the CNA's but they have been busy.R12's face sheet shows diagnoses of cerebral infarction, cognitive social or emotional deficit following cerebral infarction, generalized anxiety disorder, psychotic disorder with delusions, major depressive disorder, and other schizophrenia. R12's MDS dated [DATE] shows he is moderately impaired in cognition. R12 is dependent with personal hygiene. R12's care plan dated 426/25 shows he requires assistance with ADLs (personal hygiene).4. On 9/23/25 at 9:45 AM, R44 had facial hair under her chin and stated she wanted to be shaved.R44's face sheet shows diagnoses lack of coordination, major depressive disorder, recurrent, Alzheimer's disease, and generalized anxiety disorder. R44's MDS (Minimum Data Set) dated 7/1/25 shows she has moderate cognitive impairment. R44 needs substantial/maximal assistance with personal hygiene. R44's care plan dated 11/8/23 shows she has an ADL self-care performance deficit related to Alzheimer's disease, generalized anxiety, and major depression.On 9/24/2025 at 3:00 PM, V2 (DON-Director of Nursing) stated that ADL's including shaving and nail care are done on shower days and as needed, or whenever the resident prefers. She said the CNA's (Certified Nursing Assistants) are responsible for providing ADL care.Facility's policy titled General Care (6/30/25) shows: It is the facility's policy to provide care for every resident to meet their needs. 1.the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include, but are not limited to ADL.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess a resident's nutritional needs and provide their ordered supplement.This applies to 1 of 3 residents (R93) reviewed for nutrition in a sample of 23.Findings include:On 9/23/2025 at 12:30 PM, R93 was served his lunch in his room. R93 was thin and appeared frail. V8 (Certified Nurse Assistant/CNA) said the dietary staff prepared residents' meals based on their meal tickets, including supplement drinks. R93's meal ticket said he required a renal mechanical soft diet with thin liquids. R93 meal tray drinks were a cup of cranberry juice and a carton of Lactaid milk. R93's lunch did not include a nutritional supplement drink.On 9/24/2025 at 2:00 PM, R93 was served his lunch in his room. V31 said R93's served lunch included a drink was a cup of juice, as indicated in his meal ticket. V31 said R93's meal ticket did not include a nutritional supplement drink. On 9/24/2025 at 2:25 PM, V13 (Dietician) said she was responsible for assessing all residents' nutritional needs. V13 said residents were assessed, interviewed, and reviewed for malnutrition within 24-72 hours of admission. V13 said nurses completed dietary communication slips to inform the dietary staff of the residents' diet and nutritional needs, including nutritional supplement drinks. V13 said the information was then entered into the dietary computer system, which then generated the resident meal tickets. V13 said the meal tickets instructed the dietary staff to include nutritional drinks as ordered to ensure residents received their nutritional supplements. V13 said R93 was admitted to the facility on [DATE] and transferred back to the hospital on 9/11/2025, and she was unable to complete his dietary evaluation dated 9/11/2025. V13 said R93 was then readmitted on [DATE], and his dietary evaluation currently remained incomplete. V13 said R93's ordered supplement drink was not added to his meal ticket and not provided as ordered. R93's EMR (Electronic Medical Record) reviewed on 9/24/2025, showed his Dietary Evaluation form dated 9/11/2025 was not completed. The EMR also did not show any dietary/nutrition progress note showing R93's nutritional needs were assessed.R93's nutritional care plan reviewed on 9/24/2025, showed it was initiated on 9/17/2025 and remained incomplete. R93's specific diet and nutritional supplement needs were not identified.R93's Order Summary Report showed an order dated 9/18/2025 for (Supplement Drink) every day shift for supplement kitchen to provide at lunch. R93's readmission [DATE]) Diet Order & Communication Form slip did not include his ordered supplement drink. The facility's policy dated Nutritional Assessment and Care dated 10/01/2023, said All residents receive nutritional assessment for the purpose of identifying and planning care based on the needs, goals, and preferences of each resident. Purpose: To ensure all residents' nutritional status is assessed. To ensure all residents have individualized care plans reflecting their needs and preferences for care. To provide guidance for caregivers to ensure residents maintain an appropriate level of nutritional care. Procedure: 1. Upon admission, each resident will be interviewed by the Registered Dietitian/Nutritionists.within 24-72 hours. The facility's policy dated Nutritional Supplementation dated 10/01/2023, said Oral nutritional supplements (ONS) can also be utilized within the limitations of the resident's medical condition, as recommended and/or ordered by the physician.To provide nutrition supplementation for residents identified as needing additional support to maintain or improve their nutritional status.4. The order will be communicated to Food and Nutrition Services (FANs) via the EMR or appropriate diet change communication form per facility policy.

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F 0698 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to communicate a resident's new dialysis site order to the dialysis team and assess for post-dialysis complications. This failure resulted in the resident developing acute right arm pain and swelling from his AV (Arteriovenous) fistula site and requiring hospitalization for management of an acute cephalic vein thrombosis.This applies to 1 of 3 residents (R93) reviewed for hemodialysis in a sample of 23.Findings include:On 9/23/2025 at 3:20 PM, V9 (R93's Family Member) said R93 required hemodialysis treatments. R93 was in bed with his right arm elevated on a pillow. R93's right arm had purplish discoloration throughout. R93 had an AV fistula to his right upper arm and a permcath (central vascular access catheter) to his upper chest. V9 said before R93 was discharged to the facility, he required insertion of permcath for his dialysis. V9 stated R93 experienced severe bleeding complications from his AV fistula at the hospital on 9/8/2025. R93 was then admitted to the facility on [DATE]. V9 said R93's hospital discharge instructions included for the facility to ensure R93's permcath be used for his dialysis treatments, and not the AV fistula. V9 said on 9/11/2025, after R93 received his dialysis treatment on 9/10/2025 (at the facility), she noted his right upper arm was severely swollen, and he was complaining of pain. V9 said she requested the nurse on duty to assess R93's arm. V9 said she was then informed his AV fistula was used for his dialysis treatment, rather than his permcath. V9 said R93 was transferred to the hospital and was treated with intravenous heparin because he had a blood clot (thrombosis) in his right arm.On 9/24/2025 at 12:20 PM, V11 (Dialysis Registered Nurse/RN) said [Dialysis Company] provided in-house hemodialysis services at the facility. V11 said the facility was responsible for providing the company's intake staff with current dialysis treatment orders for new residents prior to admission. V11 said the facility nurses were also responsible for completing the dialysis Communication Report sheet prior to each treatment. V11 said the form was to communicate important resident dialysis care information, including any changes from their prior treatment and identified access sites. V11 said on 9/08/2025, R93 was admitted to the dialysis company system, and his treatment order included for him to receive his treatments via his right arm AV fistula. V11 said the facility did not update the dialysis team of R93's new hospital discharge order to now receive his treatment via his new permcath. V11 also said R93's Communication Report sheet dated 9/10/2025 did not indicate he had a new catheter site, nor his updated dialysis discharge instruction. V11 said she did not have access to R93's hospital records for review, which were uploaded into the facility's EMR (Electronic Medical Record) system. V11 said on 9/10/2025 she accessed R93's AV fistula site and dialyzed him. V11 said R93's site was stable after his treatment, but he had notable swelling to his arm. V11 said then V9 (Family Member) informed her of R93's order to use his permcath, not his AV fistula, due to his last treatment complications at the hospital. V11 said R93's nephrologist (V5) was notified of R93's swollen arm and gave orders for him to be transferred to the hospital. On 9/24/2025 at 12:40 PM, V12 (admission Director) said the facility's intake staff was responsible for providing the dialysis company with dialysis treatment orders prior to a resident's admission. V12 said he assumed the nursing staff was then responsible for reviewing the hospital medical record of a new admission and updating the dialysis team of any new dialysis orders after admission. On 9/24/2025 at 12:50 PM, V2 (Director of Nursing/DON) said V11 (Dialysis RN) had limited access to the facility's EMR system. V2 said the access included progress notes, nursing assessments, and physician orders, but not attached hospital documents. V2 said nurses were expected to complete a comprehensive admission assessment and document any vascular access sites. V2 said nurses should also review and ensure hospital instructions were followed. V2 said if any discrepancies were identified, nurses should contact the physician or hospital discharge nurse for clarification. V2 said nurses should also be monitoring and assessing residents closely for complications after dialysis. On 9/25/2025 at 12 PM, V5 (Physician/Nephrologist) said he was contacted on 9/11/2025 regarding R93's post-hemodialysis complication to his right arm AV fistula site. V5 said the clinical team members involved in the resident's care should have appropriate access to their medical record to ensure important information is communicated. V5 said the dialysis team depends on critical dialysis treatment notes and orders for review to ensure residents receive their treatments as ordered. V5 said R93's complicated stenosis from his AV fistula was most likely ongoing, and that is why his permcath was placed prior to discharge from the hospital. V5 said R93's post-dialysis complication from his treatment on 9/10/2025 could have been avoided if the dialysis team had been informed of his updated treatment orders to not use

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to secure resident medications. This applies to 3 of 3 residents (R15, R78, R95) reviewed for medications in a sample of 23.The findings include: 1.On 9/23/2025 at 10:30 AM, R78 had a medication cup containing six (6) tablets of various shapes and colors on her bedside table. The medication cup had a handwritten label with the resident's name and room number and was covered by another plastic medication cup placed on top of the medication. The contents of the cup included: 1 small orange tablet 1 small round black tablet 2 small round white tablets 1 medium-sized round white tablet 1 large oval tablet R78 stated she refused her medication, and that a nurse from a previous shift had left the medications in her room. On 9/26/2025 at 11:30 AM V2 (DON—Director of Nursing) stated that all medications should be secured and in the med cart because residents shouldn't be taking medications if they aren't assessed. V2 also stated there are residents that wander, and somebody might take another resident's medication. Facility's policy titled Medication Storage, Labeling, and Disposal dated 7/2/25 shows: 3. Medications will be stored safely under appropriate environmental controls. 4. Medications will be secured in a locked storage area. 2.On 9/23/2025 at 10:30 AM, R95 had a vial of Sooth XP eye drops lubricant on her bedside table. 3.On 9/23/25 at 11:25 AM, R15's Nystatin powder was on her bedside table.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and assist residents in obtaining routine dental services.This applies to 2 of 3 residents (R57 and R58) reviewed for dental services in a sample of 23. Findings include:1. On 9/23/2025 at 9:50 AM, R58 said he and his wife (R57) had been residing at the facility for a long time and had not seen a dentist. R58 said they both needed routine dental care services. R58 had upper and lower missing and broken teeth, with visible decay. On 9/24/2025 at 4:00 PM, V4 (Social Services Director/SSD) said the facility provided in-house dental services for all residents identified with dental care needs. V4 said social services was responsible for following up with residents who also requested in-house dental services. V4 said the dental company provided monthly services at the facility, and they assisted residents in enrolling in their dental service program.R58's MDS (Minimum Data Set) dated 7/07/2025 showed an admission date of 10/21/2024. The MDS said R58 was cognitively intact. R58's Foot and Oral Health Evaluation form dated 7/06/2025 said R58's oral cavity was assessed, and no abnormalities were identified, including obvious or likely cavity or broken natural teeth. The form did say R58 Required Dentist evaluation- assessment may indicate need for Dental check-up as soon as possible.2. On 9/23/2025 at 3:35 PM, R58 said R57 did not eat much for lunch. R58 said his wife (R57) was confused, and he also wanted her to be seen by a dentist because her lower partial dentures were missing. R58 continued to say they did not have much income, and he was unsure how they could receive dental services at the facility. R57's upper dentures were loose-fitting, and her lower front teeth were missing.R57's MDS dated [DATE] showed an admission date of 1/25/2025. The MDS said R57's oral/dental status was assessed, and no abnormalities were identified, including Broken or loosely fitting full or partial dentures.R57's Foot and Oral Health Evaluation form dated 7/20/2025 said R57's oral cavity was assessed, and no abnormalities were identified, including Broken or loosely filling full or partial dentures. The form did say R57 Required Dentist evaluation-assessment may indicate need for Dental check-up as soon as possible.On 9/25/2025 at 10:35 AM, V3 (Assistant Director of Nursing/ADON) said nurses were responsible for accurately completing residents' routine oral assessments. V3 said based on the assessment forms, the nurses then informed social services if a resident was identified in need of dental services to ensure they received routine dental care. On 9/25/2025 at 10:15 AM, V4 (SSD) said R57 and R58 were not referred to the dentist because she was not aware of their identified dental care needs or requests. V4 said she was informed verbally of new resident dental referrals. V4 said she was not aware of the facility's Foot and Oral Health Evaluation form. V4 said she also was not sure who was responsible for completing the assessment form and how the identified need for dental services was then communicated.The facility's document titled Residents on Dental Program dated 9/25/2025 did not include R57 and R58. The facility's policy titled Dental Services Policy dated 6/30/2025, said The facility will assist all residents in obtaining dental services according to the resident's needs, subject to the federal and/or state regulations.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility kitchen staff failed to follow sanitary practices and safely store food items in the kitchen.This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen.Findings include:The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated 9/23/25 documents the total census was 83 residents. On 9/23/25 at 10:31 AM, V13 (Dietician) said all 83 residents eat from the facility kitchen.On 9/24/25 starting at 11:46 AM, the following observations were made in the facility kitchen during lunch service preparation:1.At 12:36 PM, V17 (Dietary Manager) dropped the thermometer probe cover on the kitchen floor, then picked it up from the floor and placed it on the prep table where lunch temperatures were being checked. V17 did not clean the probe cover or the preparation counter. 2. At 12:21 PM, V19 (Cook) picked up the uncovered thermometer probe off the prep table, did not clean it with alcohol wipe, and then stuck the probe into the shrimp to check temperature.3. At 12:56 PM, V17 (Dietary Manager) set the thermometer probe down on the prep table right next to the contaminated probe cover, then picked up the thermometer and brought it into walk-in freezer and placed the probe into the pasta salad without cleaning the probe with alcohol.4. At 12:38 PM, V17 (Dietary Manager) was checking the temperature of a tray of pasta salad. V17 was holding a used alcohol wipe in her left hand and the thermometer probe in her right hand, and she used the alcohol wipe to push the pasta off the thermometer probe back into the large tray of pasta salad.5. At 11:46 AM V19 (Cook) was observed wearing the hair restraint only covering the hair on the back half of her head and hooked under her ear lobes to stay on her head. V19 was noted with loose hair on the top of her head, her forehead, and her temples that was not restrained by hair net. During this time V19 was hands on with lunch preparation and was leaning over the steam table counter, checking temperatures of food items.6. Pureed dinner rolls were on top of the steam table in a medium silver container, uncovered. V18 (Regional Director of Operations) said the pureed rolls should be covered up until lunch service begins.7. At 1:04 PM, the scooper used for the thickener was seen being stored on the preparation counter next to the preparation sink, not contained and within splash distance.On 9/23/25 starting at 9:46 AM, the facility kitchen was toured in the presence of V13 (Dietician), V17 (Dietary Manager), and V18 (Regional Director of Operations) and the following was found:In the walk-in cooler8. A bag of pulled turkey in cardboard box labeled with delivery date of 8/22/25 and the bag showed a packed on date of 4/15/25. There was no expiration date, use by date, or thaw date anywhere on the pulled turkey and it was fully thawed.9. A cardboard box labeled green peppers with a zucchini inside that had multiple white fuzzy spots on it. V13 (Dietician) said, It appears moldy.10. A cardboard box of 13 green peppers with black spots all over them and mushy black areas. V13 (Dietician) said, I wouldn't eat it, and if I wouldn't eat it, I can't serve it.In the dry storage:11. A bin labeled thickener with scoop stored on top of the bin, not contained, open to environmental contaminants.12. 3-32 fluid ounce bottles of 100% prune juice with best before date of 9/20/25. V13 (Dietician) and V17 (Dietary Manager) said they can no longer serve the juice to the residents because it is past the best by date.On 9/25/25 at 1:23 PM, V18 (Regional Director of Operations) said foods in the facility kitchen are labeled and dated to maintain food freshness, safety, quality, and palatability. V18 said when a food item is pulled from the freezer and placed in the cooler to thaw, it should be labeled with a thaw date, so the staff know how many days they have left to safely serve the thawed item to the residents. V18 said scoops for dry food items should be stored outside of the food container and contained/covered. V18 said the scoops need to be covered/contained for infection control purposes and to make sure dust or debris do not get on the scoops and lead to contamination of the food item and/or illness of the residents. V18 said food items past their expiration or best-by date should be removed from storage by the end of service on the marked date so the staff don't accidentally serve the food item to the residents past the marked date, with the possibility of it leading to resident illness and/or poor quality. V18 said vegetables should not be kept in food storage when they have fuzzy white spots or mushy black spots on them. V18 said hair restraints in the kitchen need to be worn covering all of the hair on the staff member's head to prevent contamination of food from hair and sweat. V18 said if a thermometer probe is cleaned and then set down on the prep table with the probe touching the table, it needs to be cleaned again prior to being used to check temperature of food item to prevent cross contamination from the prep table into the food item. V18 said the thermometer probe cover being dropped on the kitchen floor and then placed on the prep table is a concern for cross contamination and resident illness. V18 said the probe cover

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	145433	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of St Charles	611 Allen Lane Saint Charles, IL 60174

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain and monitor residents' personal refrigerators.This applies to 3 of 3 residents (R6, R40 and R74) reviewed for personal refrigerators in a sample of 23.Findings include: 1.On 09/23/2025 at 10:20 AM, the freezer section of R40's personal refrigerator was completed filled with accumulate ice built up over the freezer door. The freezer door was frozen closed and could not be opened. The freezer log for R40's personal refrigerator had not been done on September 8th, 9th, or 10th 2025. 2.On 09/23/2025 at 10:32 AM, R6's personal refrigerator contained a 1lb (pound) 3oz (ounce) bottle of strawberry fruit spread that expired June 2023. Half of the freezer section was built up with ice. The refrigerator had a melted cup of strawberry ice cream, and the bottom of the refrigerator was dirty with un-identifiable crumbs. The refrigerator temperature log had not been completed September 5th -10th, 2025 and September 20th -22nd, 2025. On 09/24/2025 at11:22 AM, V25 CNA (Certified Nursing Assistant) stated the CNAs are not responsible for resident refrigerators. On 09/24/2025 at 11:33 AM, V21 CNA stated housekeeping is responsible for cleaning and defrosting the resident refrigerators. CNAs monitor the temperature logs. On 09/24/2025 at 11:25 AM, V22 Housekeeping Supervisor stated housekeeping is responsible for logging the refrigerator temperatures and cleaning the refrigerators. Housekeeping will notify the CNA if there is outdated or spoiled food items. The temperature range is monitored to assure the food is stored at the correct temperatures. If the temperature is not in the correct range maintenance is notified. Maintenance is responsible for defrosting the refrigerator. If there is excessive ice accumulation the staff should notify maintenance. The facility policy Refrigerator and Resident Appliance Maintenance Service dated 7/3/25 states the maintenance department or facility designee is responsible for maintaining the resident appliance e.g. refrigerators are safe, clean and operable at times. The facility will perform resident refrigerator checks. Temperature is maintained using a thermometer. Proper labeling, storage and disposition of food items. Ensure proper dating and disposition of outdated food items including food brought by family and resident from the outside. 3. On 9/24/2025 at 10:29 AM R74's refrigerator had no thermometer inside. Inside there was BBQ sauce, salad dressing, a piece of chicken breast with [NAME] dressing on a plate wrapped in saran wrap undated and unlabeled. On 9/24/2025 at 3:00 PM, V2 (DON—Director of Nursing) stated that housekeeping is responsible for checking the temperature in resident refrigerators. She said that CNA's (Certified Nursing Assistants) are responsible for labeling and dating the food. She said, CNA's are responsible for disposing expired food. Maintenance is responsible for defrosting the refrigerator. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Food from the Outside (6/30/25) shows: 1. All food brought in by visitors and family members from the outside of the facility will be labeled with the date it was brought to the facility. 3. After 3—5 days, these food items will be discarded. 4. All undated food items will be discarded to ensure safety of the residents.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review the facility failed to coordinate and maintain documentation of hospice care activities and the hospice care plan.This applies to 4 of 4 residents (R10, R13, R34, and R62) reviewed for hospice care in a sample of 23.Findings include: On 09/25/2025 at 10:05 AM, V26 (Hospice RN - Registered Nurse) stated the hospice staff document their care and progress notes in their electronic computer system, not the facility's. They do not provide copies of their electronic documentation to the facility. The facility staff is updated verbally. V26 stated the only documentation provided to the facility is the admission packet, DNR (Do Not Resuscitated), POA (Power of Attorney), admission assessment, history and physical. Physician orders may be communicated verbally by the hospice doctor, ordered by the nurse practitioner, or written on an order form.On 09/25/2025 10:52 AM, V20 (RN assigned to R10 and R34) stated there should be notes in the hospice binder from the hospice nurse and hospice CNA (Certified Nursing Assistant). The hospice staff also verbally updates the facility staff. V20 states she only writes a hospice progress note when she reaches out to them. Hospice staff document in the hospice binder themselves.On 09/25/2025 at 11:11 AM, V27 (RN assigned to R62) stated the hospice staff documents in the hospice binder after their visits. V27 states the hospice nurse visits weekly and the CNAs visit twice per week. The hospice CNA will give her the shower sheet to review. The Hospice nurse places her documentation in the hospice binder and speaks to her directly. V27 stated she only documents hospice notes when she initiates contact with them.On 09/25/2025 at 12:04 PM, V28 (RN assigned to R13) stated she communicates verbally with the hospice nurse when she visits. The hospice visit notes should be kept in the resident's hospice binder. The hospice CNA will verbally provide updates of their care and any concerns. The hospice staff should be placing the care plans and visit notes in the binder themselves. V28 stated she would look in the binder for hospice staff if she had been away and didn't speak to them directly.On 09/25/2025 at 12:50 PM, V2 DON (Director of Nursing) the hospice staff provides verbal updates, and the facility nurse should document conversations and changes in the electronic medical record. The hospice staff document in their own electronic medial record not the facility record. The Hospice staff does not provide the facility copies of their documentation. The hospice nurse generally visits weekly, and the CNAs visit twice per week unless there is a change, and they need to come out more often. Hospice staff should be signing the visit log when they visit. There should be a care plan specific to hospice in the binder for staff to reference that the hospice staff should be updating.1.R10's physicians orders showed admit to hospice on 6/5/25 dated 6/17/24, The hospice binder contained her POA (Power of Attorney) for healthcare, hospice consent dated 6/5/25, a visit summary dated 5/11/25, a pre-admit evaluation dated 6/5/25, a POLST (Physician Order for Life Sustaining Treatment) signed and dated by POA on 6/5/25, and hospice physician orders dated 8/14/25. The hospice binder did not include any hospice visit notes. The facility did not provide any hospice after-visit notes. R10's facility care plan (initiated 6/5/2025) showed R10 is receiving hospice services from [hospice company], my admitting diagnosis is malignant neoplasm of the brain. The only goal on the care plan is I will verbalize comfort or be comfortable as much as possible as exhibited by lack of signs and symptoms of pain and discomfort throughout next review. Three interventions were listed on R10's facility care plan for hospice, including I am kept as comfortable as possible at all times, my (nurse/social worker) may contact [hospice company] IDT (inter-disciplinary team) for to provide update of my condition, and my nurse may provide me with pain medication if there is sign and symptom of pain or if pain is anticipated. 2.The hospice binder for R13 contained the case sheet, POA form, designation of attending physician form, hospice consent dated 5/29/25, pre-admit evaluation dated 5/29/25, hospice physician orders dated 5/29/25, a long-term care facility change in billing dated 5/29/25, the POA signed POLST dated 5/28/25 and the hospice care provider sign in log last dated 7/25/25. The hospice binder did not have any other hospice visit documentation. The facility did not provide any hospice after-visit notes. R13's facility care plan (initiated 5/29/2025) showed R13 is receiving hospice services from [hospice company], with my admitting diagnosis to hospice, senile degeneration of the brain. The only goal on the care plan is I will verbalize comfort or will be comfortable as much as possible as exhibited by lack of signs and symptoms of pain and discomfort throughout next review period. Three interventions were listed on R13's facility care plan for hospice, including I will be kept as comfortable as possible at all times, my (nurse/social worker) may contact [hospice company] regarding my care to provide update of my condition, and my nurse may provide me with pain medication if there is sign and symptom of pain or if pain is anticipated. 3.R34's hospice binder contained hospice physician orders and

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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. Based on observation, interview, and record review, the facility failed to perform hand hygiene and change gloves when rendering care, and ensure urinary drainage bags were kept off the floor.This applies to 3 of 3 residents (R44, R58, and R63) reviewed for infection control in a sample of 23.Findings include:1. On 9/23/2025 at 9:50 AM, R58 was in bed, and his full urinary catheter drainage bag was directly on the floor. Then V8 (Certified Nurse Assistant/CNA) entered the room and said she was going to assist R58 with his routine morning care. V8 donned PPE (Personal Protective Equipment), including gloves. V8 applied a new incontinence brief to R58 and assisted R58 with putting on his pants. V8 put R58's catheter tubing and bag inside his pant leg and then placed the bag directly on the floor. V8 proceeded to place R58's soiled clothing in the soiled bin and then put R58's slippers on him. V8 assisted R58 into his wheelchair and then combed his hair. V8 did not change her gloves in between R58's different care activities. 2. On 9/23/2025 at 10:35 AM, R44 was in bed. V8 and V10 (CNAs) said they were going to change R44's soiled incontinence brief. V10 cleaned R44's peri-area and removed his gloves and applied hand sanitizer. V10 then donned a new pair of gloves, which he obtained from his uniform pocket. V10 proceeded to clean R44's buttock area. V10 again removed his gloves, applied hand sanitizer, and then donned a new pair of gloves taken from his uniform pocket. V10 then applied a new incontinence brief to R44.3. On 9/24/2025 at 10 AM, R63 was in bed and her full urinary catheter drainage bag was directly on the floor. At 12:20 PM and 2 PM, R63 was still in bed, and her full urinary catheter drainage bag remained directly on the floor.Then, at 2:40 PM, V6 and V7 (CNAs) said they were going to assist R63 with her care. R63's urinary drainage bag was still on the floor. They donned PPE, including gloves. V7 obtained her pair of gloves from her uniform pocket. V6 cleaned R63's catheter tubing and removed his gloves, applied hand sanitizer, and then used a washcloth to dry the sanitizer off his hands. V6 proceeded to clean R63's peri-area and again removed his gloves, applied hand sanitizer, and dried it off with a washcloth. V6 then applied a clean brief and proceeded to dress R63 and apply her shoes. V6 did not change his gloves. V7 continued to assist V6 by repositioning R63 while he rendered her care. They then transferred R63 with a mechanical lift into her wheelchair. V6 and V7 did not change their gloves and perform hand hygiene in between R63's different care activities. On 9/25/2025 at 9:55 AM, V3 (Assistant Director of Nursing/ADON) said nursing staff were expected to perform proper hand hygiene and change their gloves when transitioning between different resident care activities. V3 said gloves should never be stored inside staff uniforms because they would no longer be considered clean. V3 said staff were also expected to properly use hand sanitizer, which required them to rub their hands together to dry off the sanitizer and should not use a towel to remove it. V3 said proper use of gloves and hygiene were important to prevent the spread of infections. V3 continued to say residents with urinary catheters were at further risk for infection, and staff were responsible for ensuring drainage bags were placed inside a protective bag and always be kept off the floor. The facility's policy titled Glove Use dated 3/23/2023, said Objectives 1. To prevent the spread of infection.When gloves are indicated, use disposable single-use gloves.Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient.The facility's policy titled Hand Hygiene dated 6/30/2025, said 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 in regards to hand hygiene.The facility's policy dated Urinary Catheter Care dated 7/03/2025, said The purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control.b. Be sure the catheter tubing and drainage bag are kept off the floor.