STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145665	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at the Lake,the	2534 Elim Avenue Zion, IL 60099

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to identify, assess, and implement treatment orders for a resident who had facility acquired pressure ulcer. This applies to 1 of 3 residents (R3) reviewed for pressure ulcers in the sample of 6. The findings include: On 12/5/25 at 10:05 AM, R3 was in his wheelchair self propelling down the hallway. R3 said he has pain to his bottom that started about two weeks ago. R3 said it's a sore on his right buttock, he does not have a dressing or cream being applied. R3 said he reported this to the staff, but nothing was done. On 12/5/25 at 10:07 AM, V9 (Licensed Practical Nurse-LPN) said R3 reported pain to his bottom about two weeks ago. He was referred to wound care and it was checked out and she was told it was not pressure. V9 said it was a dime size area to his right buttock that looked like a healed wound. R3 is not getting any treatment to his backside. On 12/5/25 at 10:48 AM, V14 (Wound Nurse), V9 (LPN) were in R3's room for a skin check. R3 was lying in his bed, he pulled down his pants and a dime size open area to his right buttock was present with no treatment in place. V14 said there was an area on his bottom a few weeks ago they were monitoring and now it's an open. She said at that time barrier cream was ordered. V14 said she was not aware of R3's open area until today. Staff should be monitoring skin daily, report new skin alterations and should be applying the barrier cream. This surveyor informed V14 the barrier cream was not found in his room. V14 went back in R3's room to find the cream, R3 was upset and irritated, and said to V14 what are you looking for, I don't have cream, where would I get it. V14 could not locate the barrier cream in R3's room and said he should have had the cream for protection. V14 said R3's right buttock area is a new pressure injury. On 12/5/25 at 1:00 PM, V14 (Wound Nurse) said she could not locate wound notes for the skin alteration that was identified a few weeks ago. V14 said she will assess the wound and obtain treatment orders. R3's Physician Order Sheets dated December 2025 shows orders on 11/7/25 to apply house stock incontinence barrier cream to buttock and moisturizer .may keep at bedside as needed daily and every shift. R3's Skin and Wound Note dated 11/10/25 shows new admission to the facility skin/wound assessment shows no history of chronic wounds and no wounds on current exam (R3) has risk factors that may contribute to wound formation, impaired functional mobility, bowel incontinence, and peripheral vascular disease. R3's Electronic Health Record (EHR) does not show documentation of R3's skin's alteration to his right buttock. R3's current care plan shows he has the potential for pressure ulcer development, Braden score of 19 with interventions including to administer treatments as ordered, apply house stock moisturizer daily and as needed, assess for pain, monitor/document/report to MD as needed changes in [NAME] status .weekly monitoring of wounds, assessments, recommendations, measurements. The facility's Skin Regimen and Treatment Formulary Policy revised July 2025 states, It is the policy of this facility to ensure prompt, identification, documentation and to obtain appropriate treatment for residents with skin breakdown .charge nurses must document in the EHR any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained form the patient's physician . prevention a) topical moisturizer applied .b) incontinent moisturizer barrier cream

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