STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146128	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Place	315 North LA Grange Road LA Grange Park, IL 60526

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor, and provide timely medical interventions for a resident with cloudy urine, thick sediments and an indwelling catheter.This applies to 1 of 1 resident (R10) reviewed for urinary tract infection (UTI) and catheter care in the sample of 18. The findings include:R10 was admitted to the facility on [DATE]. R10's face sheet showed multiple diagnoses including pressure ulcer of the right ankle, pressure induced deep tissue damage of right heel, major depressive disorder, hearing loss, fatigue, neuromuscular dysfunction of the bladder, muscle wasting and atrophy, protein calorie malnutrition, and chronic respiratory failure. R10's active physicians' orders showed R10 has an external urinary catheter for neurogenic bladder and an order for catheter care to be provided every shift. R10's active care plan dated December 16, 2025, showed R10 has a size 16 French catheter in place. R10 is at risk for infection related to the presence of an indwelling urinary catheter and improper catheter care related to neuromuscular dysfunction of bladder. The staff should empty drainage bags regularly and monitor, record, and report to physician any signs and symptoms of UTI. Signs and symptoms of a UTI include pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns.On February 24, 2026, at 11:40AM, R10 was alert and lying in bed. R10's urinary catheter bag was attached to the bed frame and contained dark, cloudy yellow urine with large, long white thick clumps of sediment.On February 25, 2026, at 9:01AM, R10 was sitting in the dining room eating breakfast. R10's urinary catheter tubing consisted of yellow cloudy urine and large thick white clumps of sediment.On February 25, 2026, at 11:27AM, V9 (Certified Nurse Assistant) said that V9 had been trained in catheter care and the training consisted of cleaning the residents and emptying the catheter bags. V9 said that when observing residents with urinary catheters, V9 looks for blood, cloudiness, thickness, and darkness in the tube or catheter bag and alerts the nurse on duty if there are any such findings. V9 said catheter bags are checked and emptied frequently. V9 said that there were no observations or concerns with R10's catheter during the shift. V9 did not receive reports from previous shift regarding any unusual occurrences with R10's urinary catheter. V9 said there were no observed signs of possible infection for any of the residents in the assignment.On February 25, 2026, at 11:35AM, V10 (Agency Licensed Practical Nurse) said that catheters are changed according to doctors' orders and signs of infection would prompt the nurse to call the physician to obtain an order. A urine sample would need to be obtained to rule out UTI. V10 said that signs of infection would include sediment or blood in tubing, and cloudy urine. V10 said that sediment would look like clumps of solid substance. V10 said that she is not aware of any concerns regarding R10's urinary catheter. V10 said that she was not informed during shift-to-shift report or by V9 that R10's catheter consisted of sediment and cloudy urine.On February 25, 2026, at 11:47AM, V2 (Director of Nursing) said that urinary catheters are changed as needed. V2 said that nursing staff should be looking for discoloration, discharge, holes in tubing, and other signs of potential infection. When this is noted, the nurse on duty should obtain orders from the doctor to change the catheter (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing and bag and address interventions to rule out a possible UTI. V2 said that currently there were no concerns with any of the residents with urinary catheters having infection, however the insertion of the urinary catheter puts the residents at a greater risk of obtaining an infection. V2 said that she was not made aware of the conditions regarding R10's catheter and confirmed that the physician should have been notified and orders should have been obtained.Progress notes were reviewed from February 1, 2026, to 12:00PM on February 25, 2026, and did not show any entries reported regarding the condition of R10's catheter, reporting to physician, or orders to address potential UTI.The facilities Urinary Catheter Care Policy date March 01, 2022, showed the purpose is to prevent catheter associated urinary tract infections.The guideline for changing catheters showed that10.) Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when closed system is compromised.The complication guideline showed12.) Observe the resident for complications associated with urinary catheters. b.) Check the urine for unusual appearance (i.e. color, blood, etc.) e.) Observe other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician and supervisor immediately.The documentation guideline showed: The following should be recorded in the resident's medical record:49.) Date and time that catheter care was given.50.) The name and title of individual giving care to catheter.51.) All assessment data obtained when giving care to catheter.52.) Character of urine such as color (straw colored, dark, or red), clarity (cloudy, solid particles, or blood) and odor.57.) Signature and title of person recording the data.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to document pain assessment, failed to document in the eMAR (electronic Medical Administration Record) the opioid medication that was administered, and failed to monitor and document for the effectiveness and/or adverse effects of the administered opioid medication to ensure that a resident's pain was managed.This applies to 1 of 4 residents (R87) reviewed for pain management in the sample of 18.The findings include:R87 was admitted to the facility on [DATE] with multiple diagnoses including aftercare following joint replacement surgery and presence of right artificial knee joint, based on the face sheet.R87's admission MDS (minimum data set) dated February 13, 2026 showed that the resident was cognitively intact. The same MDS showed that the resident was identified with occasional pain with pain intensity of 5 and receives scheduled pain medication and PRN (as needed) pain medication.On February 23, 2026 at 11:00 AM, R87 was sitting in her wheelchair inside the room. R87 was alert and oriented. R87 stated that she was having pain on her right knee and calf area. R87 described the pain as aching, throbbing and constant. R87 stated that her pain level was 6/10 (0 meant no pain and 10 meant worst pain). According to the resident, she recently had a right knee replacement. V8 (RN/Registered Nurse) was informed of R87's complaint of pain.On February 24, 2026 at 10:35 AM, R87 was in bed, alert and oriented. R87 complained of right lower leg throbbing pain and scored her pain level as 9/10. R87 stated that she received acetaminophen (pain medication) that morning at around 9:00 AM. According to R87, because her pain is strong at the time of the interview, she wanted to take a more powerful pain medication, especially because she is also scheduled to receive therapy that morning. At 10:38 AM, V8 (RN) was informed of R87's complaint of pain. While inside R87's room, the resident informed V8 that her pain was between 8 and 9/10, described as shooting pain up and down her right leg. R87 informed V8 that it was a new onset of pain, because it is constant and was not stopping. R87 stated that since her pain is severe, she wanted to take one (1) tablet of the oxycodone (opioid). At 10:52 AM, V8 prepared and administered oxycodone HCl (Hydrochloride) 5 mg (milligrams), two .5 (half) tablets (total of 1 tablet).On February 25, 2026 at 10:49 AM, R87 was sitting in her wheelchair inside her room. R87 stated that she just came back from therapy and was feeling good. R87 was asked about her complaint of right leg pain made on February 24, 2026 during the morning before therapy. R87 stated that she received oxycodone medication. According to the resident, after taking the oxycodone, she was relieved of some of the pain which made her able to do therapy but admitted that she still had some pain and was not fully relieved.R87's active order summary report showed an order dated February 10, 2026 to administer Oxycodone HCl oral tablet 5 mg. To give 0.5 tablet by mouth every 6 hours as needed for pain scale of 4-6 and give 1 tablet by mouth every 6 hours as needed for pain scale of 7-10.R87's electronic individual resident-controlled substance record (controlled medication receipt) showed that V8 (RN) administered oxycodone HCL 5 mg, 1 tablet, on February 23, 2026 at 11:19 AM and on February 24, 2026 at 11:04 AM.R87's eMAR (electronic Medication Administration Record) showed no documentation that V8 administered oxycodone to the resident on February 23 and 24, 2026. Further review of the same eMAR showed documentation made by V8 during her shift that R87 had a pain level of 2 on February 23, 2026 and a pain level of 0 on February 24, 2026.R87's progress notes for February 23 and 24, 2026 showed no documentation created by V8 regarding the resident's complaint of pain, site of the pain, assessment of the pain, pain level and assessment/monitoring of the effectiveness of pain medication (oxycodone) that was administered.R87's active care plan initiated on February 20, 2026 showed that the resident had a potential for pain related to right knee replacement and generalized pain. The same care plan showed multiple interventions including administration of pain medication as ordered, monitoring and documentation for probable cause of each pain episode, side effects of pain medication and notification of the physician if interventions are unsuccessful or if current complaint (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is a significant change from resident's past experience of pain.On February 25, 2026 at 2:15 PM, V8 (RN) was interviewed over the phone. V8 was asked if she gave oxycodone to R87 on February 23 and 24, 2026. V8 stated that she does not remember, however if she had given the said medication to R87, it will be documented on the electronic resident-controlled substance record. V8 was asked if she had documented in the eMAR that she administered oxycodone to R87. V8 was also asked if the pain assessment, site of the pain, level of pain and the monitoring for the effectiveness of the pain medication (oxycodone) that she had administered was documented in R87's electronic medical records. V8 refused to answer and requested to stop the interview.On February 25, 2026 at 2:36 PM, V2 (Director of Nursing) was informed that the interview with V8 was terminated per V8's request. During the interview, V2 was informed that R87's eMAR does not reflect the resident receiving oxycodone from V8 on February 23 and 24, 2026. V2 was informed that there was no documentation on the electronic medical record, including the progress notes about R87's complaint of pain, pain assessment, site of the pain, level of the pain that led to the administration of oxycodone and the monitoring for the effectiveness of the administered oxycodone medication. According to V2, the nurses should document in the eMAR for any medication received by a resident, including oxycodone. V2 stated that the electronic resident-controlled substance record is a record to account for the controlled medication used but is not part of the eMAR. V2 reviewed R87's electronic resident-controlled substance record and stated that since it was documented that V8, pulled out R87's oxycodone on February 23 and 24, 2026, there should be documentation on the eMAR and on the progress notes regarding pain assessment, site of the pain, level of the pain to justify administering 1 tablet of oxycodone 5 mg and the monitoring for the effectiveness of the oxycodone to ensure that R87's pain was manage appropriately and if there is a needed to administer additional breakthrough pain medication as ordered or if there is a need to call the physician for additional orders.On February 26, 2026 at 12:57 PM, V2 acknowledged that she had reviewed R87's records and agreed that the oxycodone administered by V8 on February 23 and 24, 2026 was not documented on the eMAR. V2 stated that she also did not find documentation on R87's electronic medical records regarding the resident's complaint of pain, assessment of pain, level of pain and any monitoring done to determine the effectiveness of the administered oxycodone medication.The facility policy regarding pain assessment and management revised on October 2022 showed, The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Under the general guidelines it showed -n-part, 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management . 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain. f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. 5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Under the implementing pain management strategies, it showed in-part, 4. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects and potential overdose. The same policy under monitoring and modifying approaches showed in-part, 3. Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time.The facility's policy and procedure regarding administering pain medication dated February 10, 2023 showed under documentation, Document the following in the resident's medical record: 1. Results of the pain assessment; 2. Medication; 3. Dose; 4. Route of administration; and 5. Results of the medication (adverse or desired0

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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 gloving during eye medication administration and blood glucose monitoring. The facility also failed to implement enhanced barrier precautions and use personal protective equipment during wound care. This failure applies to 3 of 3 residents (R10, R68, and R88) reviewed for infection control in a sample of 18.Findings include: 1. On February 24, 2026 at 10:09 AM, V7 (Registered Nurse/RN) prepared and administered eye drop medications to R10's Right eye. At 10:18 AM after administering eye drops (Atropine 1 % eye drops) V7 performed hand hygiene using alcohol rub/sanitizer and put on a clean pair of gloves. While wearing clean gloves V7 then removed the R10's sweater from behind R10's back and placed the sweater on the back of the resident's wheelchair. V7 then picked up and handled puzzle papers and other items from R10's bedside table. At 10:20 AM without removing used gloves, performing hand hygiene, and putting a clean pair of gloves V7 proceeded to open and administer eye drops (prednisolone 1% eye drops) to R10's right eye, and after administration dabbed R10's under eye and face with a tissue. On February 25, 2026 at 12:41 PM, V2 DON (Director of Nursing) said that V7 should have removed the dirty gloves and performed hand hygiene by using alcohol rub/sanitizer, then apply a new pair of gloves before administering the eye drop to R10 for infection control and to prevent contamination. 2. On February 23, 2026 at 4:16 PM, V11 (LPN/Licensed Practical Nurse) was outside R68's room, preparing to check the resident's blood sugar level. V11 put on a pair of gloves. While wearing the gloves, V11 touched and opened the medication cart to get the lancet (instrument used to quickly poke the skin), used her gloved hand to lock the medication cart, and then turned off/closed the computer that was attached to the medication cart, while wearing the same gloves. V11 then went inside R68's room and proceeded to check R68's blood sugar. V11 cleansed R68's left middle finger with an alcohol pad and then poked the said finger to obtain blood for monitoring, while using the same gloves. On February 25, 2026 at 12:41 PM, V2 (Director of Nursing) stated that V11 should have removed the gloves that she used to touch the medication cart and the computer, perform hand hygiene by using the alcohol rub/sanitizer, then apply a new pair of gloves before performing the blood sugar monitoring procedure. V2 stated that hand hygiene and glove changing should be performed to prevent cross contamination and to maintain infection control. The facility's policy regarding handwashing/hand hygiene last revised on October 2023 showed, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Under administrative practices to promote hand hygiene showed in-part, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The same policy under indications for hand hygiene showed in-part, 1. Hand hygiene is indicated: . g. immediately after glove removal. 2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. 3. Wash hands with soap and water. 4. Single-use disposable gloves should be used: . b. when anticipating contact with blood or body fluids. 5. The use of gloves does not replace handwashing/hand hygiene. The facility's policy regarding personal protective equipment-using gloves last revised on September 2010 showed in-part under objectives, 1. To prevent the spread of infection; . 3. To protect hands from potentially infectious material. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R88's face sheet showed she had diagnoses that include Alzheimer's disease, anxiety disorder, dysphagia, muscle weakness, pressure ulcer of sacral region, stage 3, and abnormal weight loss. R88's skin issue note dated December 8, 2025 showed a new unstageable pressure wound to the coccyx was identified. R88's Physician Initial Wound Evaluation and Management Summary dated December 9, 2025 showed the same. R88's physician progress note dated February 19, 2026 showed that R88 had a stage 3 coccyx pressure injury identified on December 8, 2025. As of February 24, 2026 at 12:38 PM, R88 lacked a physician order or care plan for enhanced barrier precautions. On February 23, 2026 10:22 AM, R88 did not have EBP signage, on or around the outside of her room door to show that R88 required enhanced barrier precautions. There was no personal protective equipment outside the door either. Again, on February 24, 2026 at 12:12 PM, R88 did not have EBP signage, on or around the outside of her room door to show that R88 required enhanced barrier precautions. Then on February 2026 at 1:19 PM, outside of R88's room, V2 (Director of Nursing) confirmed that R88's still lacked any signage to show R88 required EBP. V2 stated R88 should be on enhanced barrier precautions because of her wound. On February 24, 2026 at 12:12 PM during observation of R88's coccyx wound care, V12 (Wound Care Advanced Practice Nurse) did not don a gown before entering R88's room and measuring/assessing R88's coccyx wound. V12 had on a lab coat and leaned his right arm onto R88's bed while measuring her coccyx wound. R88 had an open wound to her coccyx which was approximately 2 centimeters in diameter. On February 25, 2026 at 1:56 PM, V4 (Infection Preventionist) stated that residents with chronic wounds, arterial, venous, or pressure ulcers should be on EBP for preventing the spread of multi-drug resistant organisms (MDROs). EBP is to keep residents safe and protect them from potential germs that staff may be carrying. V4 stated she missed identifying the need for EBP for R88. V4 stated yesterday she identified that R88 needed EBP. The facility's Infection Prevention and Control Manual Enhanced Barrier Precautions (EBP) showed the following: The purpose of enhanced barrier precautions is to prevent opportunities for transfer of MDRO's [multi-drug-resistant organisms] to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. Enhanced barrier precautions are to be implement in addition to standard precaution when other transmission-based precautions do not apply, when the facility identifies any resident with:.b) wounds or skin openings that require dressings. Personal protective equipment is required for all staff providing high-contact resident care activities including wound care.