

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Aurora		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 West Galena Boulevard Aurora, IL 60506	

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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746</p> <p>Based on observation, interview, and record review the facility failed to provide treatment and services to increase range of motion and prevent a further decrease in range of motion. The facility failed to provide Splints or supportive equipment to maintain or improve mobility. This applies to 2 of 4 residents (R26 and R43) reviewed for range of motion in the sample of 14.</p> <p>The findings include:</p> <p>1. R26 has multiple diagnosis including Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, and muscle weakness (generalized), based on the face sheet. The MDS (Minimum Data Set) assessment dated [DATE], documents that R26 is cognitively intact and has limitations with range of motion on one side for upper and lower extremities. The same MDS showed that R26 required maximum to total assistance from the staff with most activities of daily living (ADLs).</p> <p>R26 was observed on May 13, 2024, at 11:11AM in his room. R26 was observed with his left hand, arm and shoulder contracted and pulled close to his body. R26 was observed without a splint in place. R26 stated he had left side weakness related to a previous stroke and he was starting to get additional feeling back in his left hand. R26 added that he had a splint at his previous facility and that he did not have a splint since admission to the facility April 23, 2023.</p> <p>R26 was observed on May 14, 2024, without a splint in place and V2 (Director of Nursing) referred R26 for an OT (Occupational Therapy) screening.</p> <p>V12 (Occupational Therapist) was interviewed on May 14, 2024, at 10:45AM and stated that based on the screening that he would recommend a hand splint for R26.</p> <p>2. R43 had multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and monoplegia of upper limb following cerebral infarction affecting right dominant side, based on the face sheet. R43's quarterly MDS dated [DATE], showed that the resident was moderately impaired with cognition. R43's MDS showed that the resident had functional limitation in ROM on one side of both upper and lower extremities. The same MDS showed that R43 required maximum assistance from the staff with most of his ADLs (activities of daily living).</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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 13, 2024, at 11:03 AM, R43 was sitting in his wheelchair, alert, oriented and verbally responsive. R43 had weakness on his right side. R43 was not able to lift his right hand and arm and was not able to open his right hand. R43 had no device or splint on his right hand/ wrist. R43 stated that he would like to have a device or splint to help him be comfortable on his right hand/wrist.</p> <p>On May 14, 2024, at 8:58 AM, R43 was sitting in his wheelchair, alert and verbally responsive. R43 had weakness on his right side. R43 had a splint on his right hand. In the presence of V2 (Director of Nursing), R43 was asked who gave him his right hand splint. R43 stated that his mother bought the splint from an online store and gave the splint to him on May 13, 2024. R43 was asked why he was using the right hand splint. R43 responded that he feels comfortable using the right hand splint. V2 was prompted to request the therapy department to screen and/or evaluated R43 to determine the need for a device or a hand splint and any therapy services. During the same interview, R43 stated that no device was being applied on his right arm/hand during the day and/or night, except this newly bought right hand splint that was provided by his mother.</p> <p>R43's active order summary report showed an order dated January 10, 2024, for a pool noodle splint at night per OT (Occupational Therapy).</p> <p>On May 14, 2024, at 4:15 PM, V12 (Occupational Therapist) stated that he screened R43 on May 14, 2024, at around 4:00 PM per facility request. V12 stated that based on his assessment of R43, the resident's right upper extremity was non-functional because it had no muscle control and because of this, he was recommending for R43 to use a right hand splint and a right arm sling to prevent development of hand contracture, for positioning and for comfort.</p> <p>R43's rehabilitation screening form dated May 14, 2024, created by V12 showed that the reason for screening was, Per nursing request: assess need for [right] resting hand splint for anti-contracture management. The screening documented that R43's right upper extremity had no AROM (active range of motion), but PROM (passive range of motion) was within functional limits. The screening showed, [Patient was provided by family [right] resting hand splint and sling. Assess [right] resting hand splint for proper fit and use of sling. The same screening documented, OT evaluation and [treatment] to see proper fitting and schedule to wear [right] hand splint.</p> <p>On May 15, 2024 at 9:11 AM, V12 stated that he recommended the right resting hand splint for R43 to maintain his ROM (range of motion), prevent contracture and for his comfort. V12 added that he also recommended the right arm sling for proper positioning. According to V12, the resting hand splint and arm sling will be applied during the day for 2-4 hours as tolerated by R43. V12 stated that during the screening, R43 was educated and was willing to use the devices mentioned. V12 was asked about the current order to apply a pool noodle splint at night. V12 stated that he believes that R43 was seeing an outpatient therapy when he came in the facility and the outside therapy had recommended for R43 to use the pool noodle at night, however, after R43's screening on May 14, 2024, he believes that the resident does not need the pool noodle at night and would benefit more with the use of the resting right hand splint and right arm sling. V12 added that he will recommend for now, to discontinue the use of the pool noodle at night.</p> <p>50501</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36567</p> <p>Based on interviews and record review, the facility failed to have fall interventions in place for a resident that is at high risk for falls. This applies to 1 of 2 residents (R41) reviewed for falls in the sample of 14.</p> <p>The findings include:</p> <p>R41's face sheet showed diagnoses of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side, cerebral infarction, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, end stage renal disease.</p> <p>R41's MDS (minimum data set) assessment dated [DATE], showed that R41 was severely impaired in cognition. R41's fall risk assessment dated [DATE], documents that R41 was assessed to be a high risk for falls.</p> <p>On May 14, 2024, at 9:26 AM, R41 was seated in the dining room in a wheelchair after breakfast. R41 stated that he had a fall as he slipped in the room and fractured his hip and cannot walk by himself. R41 could not remember the details. R41 did not have a chair alarm on their wheelchair which was verified by V9 CNA (Certified Nursing Assistant) who was in the dining room.</p> <p>On May 14, 2024, at 12:27 PM, R41 was seated in a wheelchair in the dining room eating lunch. R41 did not have a chair alarm on his wheelchair. V9, who was seated near R41, stated that she is R41's CNA and she has never seen a chair or bed alarm since she has been here at the facility.</p> <p>On May 13, 2024, at 02:01 PM and on May 14, 2024, at 12:32 PM, V4 (MDS Coordinator) stated that R41 was walking around with a cane when he was first admitted but his Dementia got worse and he was impulsive and falls as he attempts to do things on his own. V4 stated that R41 had several falls including an unwitnessed fall sustaining a hip fracture. V4 stated that R41 currently has a chair and bed alarm, and the staff are supposed to transfer the chair pad (alarm) from the chair to the bed when they put R41 to bed. V4 added that all interventions for falls are entered in the care plan.</p> <p>On 05/14/24 at 12:48 PM, R41 was put to bed by V9 and V5 (CNA) and no chair pad alarm was seen on R41's wheelchair and on R41's bedding. V5 stated Chair pads are for those residents who try to get up by themselves.</p> <p>On 05/14/24 at 1:20 PM, V4 was notified that the chair or bed alarm was not located by staff that transferred R41 to bed. V4 stated It should have been there. V4 was accompanied to R41's room and after looking on R41's bed and R41's chair, V4 located the alarm pad in R41's closet.</p> <p>R41's fall care plan included as follows: The resident is at risk for falls related to old CVA (cerebrovascular accident) with hemiplegia on left side.</p> <p>The same care plans listed falls as follows:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>November 23, 2023: fell tripping over his sandal. No injury. Intervention included to remind resident to place sandals together out of his main walking path in his room.</p> <p>December 9, 2023: Residents family states that he is not himself. Family states he fell but did not report it. Resident complains of soreness to his left hip, sent out for evaluation. Report from hospital on December 10, 2023 states hip fracture. Interventions: included weight bearing as tolerated with supervision.</p> <p>January 13, 2024: fell emptying his trash. No injury.</p> <p>February 12,2024: fell trying to transfer for wheelchair to bed. No injury.</p> <p>March 29, 2024: fell no injury was up and down all night. Intervention included bed and chair alarm.</p> <p>Facility policy titled Fall Prevention Program (implemented January 2024) included as follows:</p> <p>Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.</p> <p>Policy Explanation and Compliance guidelines:</p> <p>3. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk.</p> <p>6 High Risk Protocols: a) Implement interventions from low/Moderate Risk Protocols.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>16746</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview and record review the facility failed to ensure that a physician's order was obtained for the administration of oxygen. The facility failed to ensure that there was water in the humidifier bottle and the oxygen nasal cannula tubing and humidifier bottle were labeled. The facility also failed to ensure that the nebulization mask was covered when not in use to prevent contamination. This applies to 1 of 2 residents (R14) reviewed for oxygen use and respiratory care in the sample of 14.</p> <p>The findings include:</p> <p>R14 had multiple diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation, and acute and chronic respiratory failure with hypoxia, based on the face sheet.</p> <p>R14's quarterly MDS (minimum data set) dated February 24, 2024, showed that the resident was moderately impaired with cognition.</p> <p>On May 13, 2024, at 11:37 AM, R14 was in bed, alert and verbally responsive. R14 had continuous oxygen via nasal cannula running at four liters per minute using an oxygen concentrator. R14 had no shortness of breath. The humidifier bottle that was attached to the oxygen concentrator and the oxygen tubing was empty (no water). R14 stated that his nostrils were dry. R14's oxygen nasal cannula tubing and humidifier bottle had no label. On top of R14's bedside table was a nebulization mask that was not covered/contained. The uncovered nebulization mask was stored on top of the bedside table beside cookies that were not in packaging. V11 (Registered Nurse) was made aware of the empty humidifier bottle and after prompting, placed a new humidifier bottle.</p> <p>On May 14, 2024, at 10:09 AM, R14 was in bed, alert, oriented and verbally responsive. R14 had continuous oxygen via nasal cannula running at three liters per minute using an oxygen concentrator. R14 had no shortness of breath. R14's oxygen nasal cannula tubing and humidifier bottle that was attached to the oxygen concentrator and the oxygen tubing had no label. V8 (Registered Nurse) who was inside R14's room acknowledged that the resident's oxygen tubing and humidifier bottle had no label. V8 does not know when the nasal cannula tubing and the humidifier were last changed.</p> <p>R14's active order summary report as of May 14, 2024, showed no order for administration of continuous oxygen via nasal cannula.</p> <p>On May 14, 2024, at 1:09 PM, V2 (Director of Nursing) stated that there should be a physician's order for the use of oxygen because it was a treatment that was being administered to R14. V2 stated that the humidifier bottle should not be empty when the oxygen concentrator is running, and that the oxygen nasal cannula tubing and the humidifier bottle should be labeled. During the same interview, V2 stated the nebulization mask should be inside a bag or covered when not in use to prevent contamination.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy regarding oxygen administration dated January 2024 showed in-part, under policy explanation and compliance guidelines, 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: . c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification. d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746</p> <p>Based on observation, interview and record review the facility failed to ensure that blister packs containing controlled medications are maintained intact to ensure safe and effective use of the medications.</p> <p>This applies to 2 of 3 residents (R4, R44) reviewed for controlled medications in the sample of 14.</p> <p>The findings include:</p> <p>1. On [DATE], at 10:38 AM with V8 (Registered Nurse) the medication cart #2 was observed with a locked controlled medication compartment. In the presence of V8, the following observations were made:</p> <p>R4 had a blister pack of Lorazepam 2 mg (milligram), dispensed by the pharmacy on [DATE], originally containing 30 tablets. The said blister pack of Lorazepam 2 mg had 28 tablets remaining that were intact and sealed (from #1 through #28), while there was one additional tablet with a broken seal that was taped over at the back (#29).</p> <p>R30 had a blister pack of Lorazepam 1 mg, dispensed by the pharmacy on [DATE], originally containing 30 tablets. The said blister pack of Lorazepam 1 mg had 29 tablets remaining that were intact and sealed (from #1 through #29), while there was one additional tablet with broken seal that was taped over at the back (#30).</p> <p>During the same observation, V8 stated that she does not know who taped the back of R4 and R30's controlled medications.</p> <p>2. On [DATE], at 11:57 AM with V2 (Director of Nursing) the medication cart #1 was observed with a locked controlled medication compartment. In the presence of V2 it was observed that R44 had a blister pack of Lorazepam 1 mg, dispensed by the pharmacy on [DATE], originally containing 42 tablets. The said blister pack of Lorazepam 1 mg had 41 tablets remaining that were intact and sealed (from #1 through #41), while there was one additional tablet with broken seal that was taped over at the back (#42).</p> <p>On [DATE], at 8:20 AM, V2 stated that taping the back of the blister pack medications or tampering the blister pack medications, including controlled substances are not acceptable and are not the practice of the facility. V2 stated that any tampered blister packs (taped at the back/seal broken) should be destroyed to prevent any drug theft, misappropriation of drugs, and to ensure the quality and safety of the medications.</p> <p>The facility's policy regarding controlled substance administration and accountability dated [DATE] showed, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The same policy under explanation and compliance guidelines showed in-part, 6 . e. If the package has been opened or the tamper seal removed, it must be destroyed.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy regarding destruction of unused drugs dated [DATE] showed, All unused, contaminated or expired prescription drugs shall be disposed of in accordance with state laws and regulations.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389</p> <p>Based on interview and record review, the facility failed to ensure that a resident received monthly medication regimen review (MRR) by a licensed pharmacist. This applies to 1 of 1 resident (R15) reviewed for medication regimen review in the sample of 14.</p> <p>The findings include:</p> <p>R15 is a [AGE] year old female who was admitted to the facility on [DATE] with medical diagnoses that include Dementia, Hypertension, Delusional Disorders, Depression, Hyperlipidemia, Osteoarthritis, and Anxiety. R15's medication orders include Seroquel 12.5 milligrams (mg) for delusional behavior, and Venlafaxine Hydrochloride Extended Release (HCL ER) Capsule 75 mg for depression.</p> <p>Review of R15's medical record on the morning of May 14, 2024 showed no medication regimen reviews completed by the pharmacist.</p> <p>On May 14, 2024 at 1:11 PM, V2 (Director of Nursing) stated the facility does not have any medication regimen reviews by the pharmacist for R15. V2 stated she checked with the pharmacist and they did not have any either.</p> <p>R15's Psychotropic medication care plan showed to consult with pharmacy.</p> <p>The facility's Medication Regimen Review policy dated 1/2024 showed the following: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. 1. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to follow food storage and thawing procedures and ensure that food service areas are maintained in a clean and sanitary manner. This applies to 44 residents that receive oral diets prepared in the facility kitchen.</p> <p>The findings include:</p> <p>Facility provided information that the census on May 13, 2024, was 46 residents, with 2 residents on NPO (nothing by mouth) status.</p> <p>On May 13, 2024, at 9:47 AM, the initial tour of the kitchen was done in the presence of V6 (Dietary Manager).</p> <p>At the dish machine, V7 (Cook) was seen at the clean side of the dish machine unloading cleaned dishes from racks that just came out of the dish machine. The cleaned dishes on the racks were atop the conveyor belt that was noted to have unidentifiable debris and food particles.</p> <p>The reach in freezer had unknown smears on the surface of the door and the bottom part of the door was eroded and had the appearance of rust. There was extensive blackish substance and debris on the inside side compartments and on the racks where food was stored. Multiple open undated hamburger patties were seen stored on one of the shelving. On the top shelf there was a tall plastic cup of half-drunk chocolate milk shake that V6 stated was not for residents.</p> <p>The reach in refrigerator also had unknown smears and dust on the door handle. The outside panel and the refrigerator was noted to be wobbling when the door was opened. A large pan half filled with water was seen on the top shelf. V6 stated that the water was collecting from a leak from the condenser and V6 had put in a request to get it fixed. Under the same pan there was a plate with sliced ham that was partially covered with a plastic wrap. Another pan contained several packs of opened deli meat (Bologna) which was opened and undated. V6 stated It's from last night. The shelves of the refrigerator were brownish grayish color where the enamel coating had worn off.</p> <p>Inside the 3-compartment sink (sanitizing well), water was running from a faucet over raw frozen unidentifiable meat in a container. The top part of the meat was exposed out of the pan and the bottom part was submerged in water in the container. Soiled dishes were seen stacked in the wash well of the 3-compartment sink. V6 stated that the 3-compartment sink was not in use and that the soiled dishes will be run through the dish machine.</p> <p>On May 13, 2024, at 11:27 AM, on return to the kitchen, the same thawing frozen meat was seen half immersed in a container of water in the 3 compartment sink. The water was not running over the frozen meat identified as 'Pork Butt' by V6. V6 added that there are 3 appropriate ways to thaw meat: in a microwave, in a refrigerator or in running water. V6 acknowledged that the water was not running over the defrosting pork butt.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The ice maker screen was covered with extensive dust which had a fan blowing on it to the food prep area and the steam table. The entire kitchen floor under the stove and shelving was covered in dust and unknown debris.</p> <p>On May 14, 2024, at 10:21 AM, the kitchen was revisited, and the above seen freezer still had extensive blackish substance on the shelving and side compartments. An undated package identified as diced chicken and an undated disposable bowl of ravioli was stored on one of the racks. The refrigerator continued to have a large pan of water collecting in it on the top shelf. Both the freezer and refrigerator had unidentifiable streaks and smears and dust on the outside panel and the door handles. The ice maker screen still had dust with the fan blowing into the food prep area. The floor under the stove and prep areas remained covered in dust and unknown debris.</p> <p>On May 14, 2024, at 10:23 AM, V6 stated that all items placed in the freezer or refrigerators should have been labeled and dated. V6 added that the kitchen is cleaned daily and deep cleaned weekly every Tuesday.</p> <p>Facility policy titled Sanitation Inspection (implemented January 2024) included as follows:</p> <p>Policy: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies, and other insects. 4. Sanitation inspections will be conducted in the following manner: <ol style="list-style-type: none"> b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. <p>Facility policy titled Food Safety Requirements (implemented January 2024) included as follows:</p> <p>Policy: Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.</p> <ol style="list-style-type: none"> 3.c. Refrigerated Storage-Practices to maintain safe refrigerated storage include: <ol style="list-style-type: none"> iv. Labeling, dating, and monitoring food, including, but not limited to leftovers, so it is used by its use-by date or frozen (where applicable)/discarded. 4. Thawing-approved methods for thawing frozen foods include thawing in the refrigerator, submerged under cold water, thawing in a microwave oven, or part of a continuous cooking process . 6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. 		