STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Aurora	1017 West Galena Boulevard Aurora, IL 60506

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on interview and record review, the facility failed to ensure that residents signed POLST (Practitioner Order for Life-Sustaining Treatment) form and the physician's order are consistent, to reflect the resident's treatment wishes in an event of a medical emergency. This applies to 3 of 3 residents (R15, R32, and R51) reviewed for advanced directives in the sample of 20. The findings include: 1. R15 had multiple diagnoses including flaccid hemiplegia affecting left nondominant side, kidney transplant status and ESRD (end stage renal disease), based on the face sheet. R15's quarterly MDS (minimum data set) dated [DATE] showed that the resident was cognitively intact. R15's EMR (electronic medical records) scanned POLST dated [DATE], signed by R15 showed that the resident selected, Do Not Attempt Resuscitation/DNR (Do Not Resuscitate). R15's active order summary report showed an order dated [DATE] to, Attempt Resuscitation/CPR (Cardiopulmonary Resuscitation). R15's active care plan initiated on [DATE] showed that the resident has a full code status and to attempt resuscitation/CPR. The same care plan showed multiple interventions including, Code status will be reviewed at least quarterly and with changes in his condition, execute any of wishes for code changes and implement any changes desired, and If code status changes the clinical record will be updated to reflect the changes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:33 PM, V7 (LPN (Licensed Practical Nurse) stated that if a resident has no pulse and no breathing, she will first check the EMR dashboard section to see the code status and then look at the code status order. V7 stated that whatever was documented on the dashboard should match the actual order and whatever the code instructions written on the dashboard and the physician's order should be followed. During this interview, V7 checked R1's EMR dashboard and the active order then stated that both sources showed that the resident is a full code and CPR should be performed. V7 was asked if she would also check if the resident had a signed POLST in EMR and she (V7) stated yes, if it is in the electronic records. V7 then looked at the EMR for R15's signed POLST. V7 stated that the signed POLST for R15 showed that the resident is DNR. V7 commented, Okay, this is confusing. V7 acknowledged that based on the EMR dashboard and active order, and the resident's signed POLST, there is a conflicting information about R15's code status. On [DATE] at 3:40 PM, V2 (Corporate Nurse) stated that the resident's signed POLST should be reflected on the physician's order. V2 was shown R1's physician order to attempt resuscitation and R1's signed POLST indicating DNR. According to V2, the two information were conflicting and needs to be looked at immediately in case of an emergency. The facility's policy for resident's rights regarding treatment and advance directives, last reviewed by the facility on [DATE] showed, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The same policy under explanation and compliance guidelines showed in-part, 3. Upon admission should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff .7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. 29562 2. Face sheet shows that R51 is [AGE] years-old who has medical diagnoses including urinary tract infection (UTI), site not specified, and hypertension (HTN). R51 was admitted to the facility on [DATE]. R51's Physician Order Summary (POS) advance directives dated February 24, 2025, shows that R51's is a full code (meaning Attempt Cardiopulmonary Resuscitation/CPR). R51's signed POLST (Practitioner Order for Life-Sustaining Treatment For) dated [DATE], showed that R51 selected, Do Not Attempt Resuscitation/DNR. On [DATE], at 3:06 PM, V2 (Corporate Nurse) stated that all orders and care plans for advance directives should follow code status or POLST. R51's care plan for advance directives shows R51 has chosen DNR (Do Not Resuscitate). This care plan was created on [DATE], after surveyor's inquiry. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36567 3. R32's EMR (electronic medical records) included diagnoses of face hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, unspecified convulsions, end stage heart failure, personal history of other diseases of the respiratory system. R32 EMR dashboard showed special instructions Full Code and POLST form uploaded in EMR showed No CPR (Do Not Attempt Resuscitation (DNAR). There was no order for advance directive on POS (Physician Order Sheet). On [DATE] at 12:33 PM, R32's nurse (V6, LPN, Licensed Practical Nurse) when asked how she determines the code status of a resident in the event of an emergency, V6 stated Usually the dashboard (of computer) will tell you if it's a DNR or full code. R32 then looked up R32's EMR and stated that he is a full code and that she will attempt full CPR (Cardio Pulmonary Resuscitation) in the advent of an emergency for R32. V6 added that sometimes the code status is also uploaded under miscellaneous section. V6 then made several attempts to look up the miscellaneous section but was unable to do so. V6 stated that she is fairly new at the facility and don't know the system (EMR) here. V10 (LPN) who was in the vicinity stated that the code status is also listed on the crash cart. On reviewing the crash cart listing for full code status R32's name was not found. V6 then remarked that she goes by the dashboard for code status of the patient as the list on the crash cart is not always updated. On [DATE] at 12:47 PM, as V6 and V7 were not able to access the miscellaneous section of the EMR with multiple tries, V2 (Corporate Nurse) was requested for R32's POLST form. V2 then confirmed that special instructions on R32's dashboard showed Full Code and POLST form uploaded in EMR showed No CPR (Do Not Attempt Resuscitation (DNAR). V2 stated that the facility process is that the social service reviews the resident's clinical records on admission and obtains the advance directive and collaborates with the nursing IDT (interdisciplinary team) to put the orders in the resident's EMR. On [DATE] at 12:55 PM, V9 (Social Service Director) stated that when she obtains a POLST form she uploads it in the system and then puts a progress note and updates the care plan to reflect what is on the POLST. V9 added that she does not enter the orders for the advance directive as its only the nurses that enters orders on POS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview and record review the facility failed to ensure residents have a comprehensive care plan, that identifies their individual needs and includes all aspects of their care including assistance needed with ADLs (Activities of Daily Living), urinary catheter care, oxygen administration, and wound care. This applies to 4 of 4 residents (R19, R51, R53 and R158) reviewed for care plans in the sample of 20. The findings include: 1. R19's admission record showed R19 was admitted to the facility on [DATE], with multiple diagnoses including diabetes type 2, essential hypertension, non-displaced fracture of head of right radius, major depressive disorder, obstructive sleep apnea, atherosclerotic heart disease. R19's MDS (Minimum Data Set) dated March 17, 2025, showed R19 had a stage 3 pressure ulcer, the presence of a pressure reducing device for bed, pressure reducing device for chair, and was receiving care and application of ointments for the pressure ulcer. R19's order summary dated April 11, 2025, showed an order for barrier cream to be applied to the coccyx every shift and as needed. On April 16, 2025, at 11:10 AM, R19's wound care was observed and R19's coccyx area remained red, V10 (LPN) stated this site was a pressure ulcer that was healing. R19's care plan initiated on November 19, 2024, did not identify a plan of care for a pressure ulcer, or a plan for prevention of pressure ulcers. 43389 2. R53's electronic medical record showed R53 is a [AGE] year old admitted to the facility on [DATE] with diagnoses that includes acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and Type 2 Diabetes Mellitus. On April 15, 2025 at 10:55 AM, R53 was receiving 3 liters of oxygen via nasal cannula. R53 has a physician order dated January 23, 2025 that showed R53 should have continuous oxygen at 2-3 liters via nasal cannula or mask. As of April 18, 2025 at 9:08 AM, R53 did not have a care plan for his continuous oxygen, respiratory failure with hypoxia, nor his chronic obstructive pulmonary disease. 29562 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R51's electronic medical records (EMR) shows that R51 is [AGE] years-old who has medical diagnoses including urinary tract infection, site not specified, and essential hypertension. Minimum Data Set (MDS) dated [DATE], shows that R51's Brief Interview for Mental Status (BIMS) is 10 (moderately impaired cognition) and requires assistance for grooming and hygiene. Though R51's BIMS was 10, R51 was unable to respond well to instructions this was confirmed by V15 (Certified Nursing Assistant/CNA) who stated that R51 is confused. R51 was observed on April 15 and 16, 2025, displaying nails with black and brown substances underneath her fingernails. R51's nail beds had brownish discoloration. R51 also has curly facial hair on her chin. R51 was verbal and able to respond to yes or no questions. However, she was unable to coherently answer questions that needed explanation. On April 16, 2025, at 1:39 PM, V15 and V22 (CNA) rendered peri-care and catheter care to R51. R51's urinary catheter was not secured or anchored. R51 also remained with brownish discoloration on her nail beds, and with black/brown substances underneath the nails. R51 remained with curly facial hair on her chin. R51 was cooperative during provision of peri-care. V15 and V22, did not attempt to secure the urinary catheter, and did not offer to provide nail care and shaving to R51. R51's care plan report was reviewed. There were no specific care plans addressing R51's ADL (activities of daily living) care pertaining to grooming and hygiene, and the care for indwelling urinary catheter. 4. The electronic medical record (EMR) shows that R158 was admitted on [DATE]. R158's past medical history include hypertension, diabetes, and osteomyelitis of the right foot. The nurse practitioner notes dated April 10, 2025, shows that R158 had a surgery on March 26, 2025, with a partial ray amputation of the right foot. R51's treatment from the hospital was completed and he was sent to the facility for wound care and antibiotic therapy. R158's nutrition/dietary notes dated April 11, 2025, shows R158 was admitted to the facility following hospitalization for infected right foot diabetic ulcer, then diagnosed with osteomyelitis. On April 15, 2025, at 11:14 AM, R158 was resting in bed, he was alert and oriented and could communicate well during interview. R158's right foot was covered with a wound dressing. R158 stated that he was diabetic, and he had a recent amputation of his right big toe about a month ago. R158 also stated that he has history of amputation of his two other right toes. From 4/15/25 through 4/17/25, R158 has been observed ambulating the hallway and going outside for smoking. R158's care plan report was reviewed. There were no specific care plans addressing R158's diabetes and diabetic wound. On April 17, 2025, at 3:01 PM, V2 (Consultant Nurse) stated that part of the grooming/hygiene is to offer shaving and nail care and if resident refuses the staff must report and document refusal and update care plan. In addition, V2 stated that comprehensive care plan should be develop and implemented within 7 days upon completion of MDS. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Policy for Comprehensive Care Plans dated January 2025 shows: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standard of quality. Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Policy Explanation and Compliance Guidelines shows: 2. The comprehensive care plan will be developed within 7 days after completion of the comprehensive MDS assessment. All Care Assessment Areas (CAA) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will be address in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. d. The resident's goals for admission, desired outcomes, and preferences for future discharge.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 29562 Based on observation, interview and record review, the facility failed to ensure grooming for residents who require assistance for ADLs (Activities of Daily Living). This applies to 3 out of 3 residents (R13, R21, and R51) reviewed for ADL care in the sample of 20. The findings include: 1. On April 15, 2025, at 1:05 PM, R51 was in the dining room, sitting in her wheelchair. R51's fingernails had black and brown substances underneath nails and nail beds had brownish discoloration. R51 also has curly facial hair on her chin. R51 was able to respond to yes or no question, however, she was unable to coherently answer questions that needs explanation. V15 (CNA, Certified Nursing Assistant) stated that R51 is confused. On April 16, 2025, at 1:39 PM, V15 and V22 (CNA) rendered peri-care and catheter care to R51. R51's nails remained with brownish discoloration on the nail bed, and with black/brown substances underneath nails, and with curly facial hair on her chin. R51 was pleasant and cooperative during provision of peri-care. V15 and V22 did not offer to provide nail care and shaving to R51 after they completed providing the peri-care. Minimum Data Set (MDS) dated [DATE], shows that R51 requires assistance for personal hygiene. On April 17, 2025, at 3:01 PM, V2 (Cooperate Nurse) stated part of the grooming/hygiene is to offer shaving and nail care and if resident refuses the staff must report and document refusal and update care plan. There was no evidence in the progress notes from April 1, 2025, to present, that R51 was refusing care, and there was no care plan showing that R51 was non-compliant with ADL care. 16746 2. R13 had multiple diagnoses including contracture on the left and right hand, based on the face sheet. R13's quarterly MDS (minimum data set) dated March 13, 2025 showed that the resident was moderately impaired with cognition. The same MDS showed that R13 had functional limitation in ROM (range of motion) to both upper extremities and required assistance from the staff with regards to personal hygiene. On April 15, 2025 at 10:57 AM, R13 was in bed, alert and oriented. R13 had accumulation of long facial hair. R13 stated that he needs help from the staff with shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 16, 2025 at 1:30 PM, R13 was in bed, alert and oriented. R13 had accumulation of long facial hair. In the presence of V2 (Corporate Nurse), R13 stated that he needs help with shaving and wants the staff to shave him. R13's active care plan initiated on November 12, 2024 showed that the resident has an ADL (activities of daily living) self-care performance deficit related to limited range of motion/contractures in both hands. 3. R21 had multiple diagnoses including lack of coordination, legal blindness and unspecified intellectual disabilities, based on the face sheet. R21's quarterly MDS dated [DATE] showed that the resident was cognitively intact and required total assistance from the staff with personal hygiene. On April 15, 2025 at 11:02 AM, R21 was in bed, alert and oriented. R21 had accumulation of long facial hair. R21 stated that he needs staff assistance with shaving and that he wanted to be shaven. On April 16, 2025 at 1:31 PM, R21 was in bed, alert and oriented. R21 had accumulation of long facial hair. In the presence of V2 (Corporate Nurse), R21 asked to be assisted with shaving. R21's active care plan initiated on January 21, 2016 showed that the resident has an ADL self-care performance deficit. The same care plan showed multiple interventions including, The resident is dependent of 1 staff for personal hygiene. On April 16, 2025 at 1:35 PM, V2 stated that it is part of the nursing care and service, and the staff are expected to assist residents needing assistance with ADL including removal/shaving of facial hair to ensure and maintain resident's hygiene and grooming.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on record review and interview the facility failed to perform CPR (Cardio-Pulmonary Resuscitation) correctly as per standards of practice, failed to call a code blue within the facility, and failed to call EMS system (911) for an unresponsive resident identified as a full code on the physician's orders in accordance with the Facility policy. This failure resulted in Immediate Jeopardy. The Immediate Jeopardy began on [DATE], at 5:25 AM, when R55, who had full code orders, expired in the facility after being found unresponsive and staff did not perform CPR as per the Standards of Practice and did not follow their policy for Medical Emergencies. V1 (Administrator) and V24 (Regional Director of Operations) were informed of the Immediate Jeopardy on [DATE], at 4:17 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but the facility remains out of compliance at a severity level two because additional time is needed to evaluate the implementation and effectiveness of the training. This applies to 31 of 53 residents (R1, R5, R10, R11, R13, R15, R17, R18, R19, R20, R23, R25, R29, R33, R36, R37, R38, R39, R40, R42, R44, R45, R47, R48, R49, R52, R53, R55, R158, R257 and R307) reviewed for code status and request CPR to be performed. The Findings include: The admission record showed R55 was admitted to the facility on [DATE], with diagnoses of fracture of the right femur subsequent encounter for closed fracture with routine healing, hypopituitarism, type 2 diabetes, chronic diastolic congestive heart failure, obstructive sleep apnea and cerebral infarction due to embolism of the cerebral artery. R55's progress note dated [DATE], at 3:00 PM showed R55 was admitted for further rehabilitation, was a full code status and transferred from another SNF (Skilled Nursing Facility), R55's hospital referral notes to prior facility dated [DATE], showed R55 had a fall on [DATE], and had surgery for femur fracture on [DATE]. R55 was hospitalized from [DATE], until [DATE]. R55 transferred to this facility on [DATE]. The transfer orders showed under advanced directives that R55 was a full code. R55's vital signs at the time of admission showed blood pressure ,d+[DATE], Pulse 62 beats per minute, Temperature 98.0 F, Respirations 18 breaths per minute and oxygen saturation was 97% on room air. The next documentation after R55's initial admission note was [DATE], at 08:04 AM written by V11 (RN) that showed R55 was found unresponsive, no pulse and cool to touch at 5:25 AM and pronounced dead by 2 nurses. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview of V11 (RN), on [DATE], at 2:10 PM, V11 stated she had seen R55 sleeping on his side with regular respirations during her first round at around 11:00 PM. V11 stated the next time she did rounds was between 2:30 AM and 3:00 AM, she observed R55 and appeared to be sleeping, but was making coughing type noises while breathing. V11 stated she did not assess R55 at that time. V11 stated the next time she saw R55 when she went to his room to administer medications at around 5:20 AM and attempted to wake R55 up but R55 did not respond. V11 stated she then turned on the light, did not find a pulse, found R55 was lying in brown, yellow stained sheets, did a sternal rub and left the room to call for help. V11 stated it appeared R55 had defecated, and stool was on the bed and on the floor. V11 stated she used the nurses desk phone to call the other nurses' station to get the other nurse, (V10) to help and told V13 (CNA) to go to R55's room. V11 stated she did not overhead page a code blue because she had never been taught how to overhead page. V11 then stated she called V14 (former DON) from her cell phone and went back to R55's room. V11 stated while on the cell phone with V14, V11 stated she started to do chest compressions for less than a minute, when V14, who was not in the facility, instructed her to stop compressions and not to call 911. V11 stated she did not bring the crash (emergency) cart to R55's room. V11 stated she was unsure what to do in the situation and was looking for guidance. V11 stated in hindsight she would have called 911 and started CPR as soon as she found R55 unresponsive. V11 stated she was unaware of R55's code status until she was contacting the funeral home. V11 stated as of now she does not know how to use the facility's intercom system to announce a Code Blue. V14 was no longer employed by the facility and not available for interview. On [DATE], at 3:47 PM, V10 (LPN) stated she worked the overnight shift with V11 on [DATE]. V10 stated she was in a resident's room when she heard the desk phone ring at the nurses' station, she was unsure of the time but said it was at the end of the shift. She stated she made the resident safe and went to answer the desk phone. V10 stated V11 was calling her to come to R55's room. V10 stated by the time she got to R55's room, V11 was talking on the cell phone to V14, so she left and did not provide any assistance and did not assess R55. V10 stated when she saw V11 talking on the cell phone she left the room and went back to her assignment. V10 stated she did not call a code blue; she did not bring the crash cart and she did not call 911. When asked about who could pronounce a resident dead in the facility, V10 stated she was not sure if the facility had a policy, but only an RN can pronounce a resident dead in the facility. On [DATE], at 3:15 PM, V13 (CNA) was working on the unit with V10. V13 stated near the end of the shift, V11 asked him to help clean R55 because the family was coming. V13 stated when he walked into R55's room he did a sternal rub, but R55 did not respond. V13 stated he thought R55 might be dead, but he also thought only a doctor could pronounce someone dead. V13 stated there was no crash cart at the room, he was not aware of a code blue and the paramedics were not in the facility. On [DATE], at 5:40 PM, V12 (Medical Director) stated if a resident is found unresponsive, without a pulse and is a full code, the paramedics should be called. V12 stated CPR should be initiated unless rigor mortis is present. V12 stated the presence of feces on or around the resident is not an indication that CPR should not be performed. R55's progress notes on [DATE], did not indicate an assessment for signs of clinical death or the presence of rigor mortis was done and was not documented. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 3:05 PM, V1 (Administrator) stated there was no investigation regarding the death of R55. V1 stated he was not the Administrator at that time, both the Administrator and Director of Nursing at the time of R55's death were no longer employed by the facility. On [DATE], at 10:30 AM, V24 (Regional Director of Operations) stated the facility does not have a policy regarding nurses determining death and pronouncing time of death of a resident. V24 stated he would have to ask the Regional Clinical Consultant what the policy should be. On [DATE], at 1:00 PM, the facility provided a list of residents in the facility with their code status and there were 30 residents (R1, R5, R10, R11, R13, R15, R17, R18, R19, R20, R23, R25, R29, R33, R36, R37, R38, R39, R40, R42, R44, R45, R47, R48, R49, R52, R53, R158, R257, and R307) identified as full code status in the facility. The Facility's policy titled Medical Emergency Response dated reviewed [DATE], showed Policy Explanation and Compliance Guidelines .1. The employee who first witnesses or is first on the sight of a medical emergency, will initiate immediate action, including CPR as appropriate . 3. A Nurse will .b. Stay with the resident . c. Designate a staff member to announce a Code Blue, notify the physician and call 911 .4. A Code Blue will be announced over the intercom system. 5. All available staff will respond to the emergency accordingly .6. The staff on the unit will take the emergency cart to the code .7. This will continue until emergency personnel arrive and resident is transported to the emergency room via EMS (Emergency Medical Services) .8. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and a. In accordance with the resident's advance directives. The facility submitted an abatement plan to remove the immediacy on [DATE], at 6:08 PM. The Survey Team reviewed the abatement plan and was unable to accept the plan and returned the abatement plan to the facility for revisions. The Facility presented a revised abatement plan on [DATE], at 12:34 PM. The Survey Team reviewed the plan and was unable to accept the abatement plan and it was returned to the facility for revisions. The Facility presented a revised abatement plan on [DATE], at 5:34 PM. The Survey Team reviewed the abatement plan and was unable to accept the third revision. The abatement plan was returned to the facility for fourth revision. The Facility submitted the revised abatement plan on [DATE], at 6:15 PM. The Survey Team accepted the abatement plan on [DATE], at 6:20 PM. The Immediate Jeopardy that began on [DATE], was removed on [DATE], when the facility took the following actions to remove the immediacy: -Administrator/ designee will provide training for all staff, initiated on [DATE], on Medical Emergency Response and CPR policy. This includes the employee who first witnesses or is first on the site of a medical emergency will initiate immediate action. The training also includes if a resident experiences cardiac arrest or unresponsiveness, the facility staff will provide basic life support including CPR, prior to the arrival of emergency medical services in accordance with the resident's advanced directives. The Training will continue until all staff have attended. Agency staff and staff who missed the training will receive training prior to working their next scheduled shift. -Administrator/designee will provide training for all staff, initiated on [DATE], on Resident Rights regarding Treatment and Advance Directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Provide Mock Code evaluation drills, initiated on [DATE], in a Mandatory Meeting and continue until all staff have attended a drill. The Mock Code Blue Audit tool will be used during the drill as a guide for staff roles and tasks during a Code Blue. The Administrator/designee will provide the training. The training will continue until all staff have been trained. -The Maintenance Director will provide training on the use of the intercom system, to announce Code Blue on the overhead page, to all staff, as part of the Mock Code evaluation drills initiated on [DATE]. The training will continue until all staff have been trained. -The facility developed a process to determine if a resident has executed an advance directive. The Social Service Director reviewed Advance Directive with the residents, initiated [DATE], and the process is ongoing. - Upon admission, the Nurse will ensure a resident with an advance directive, will communicate the resident's choice to the Health Care Practitioner and obtain the order, and provide a copy of the Advanced Directive to Social Services/designee, initiated [DATE], and ongoing. -The Facility Quality Assurance Committee (Administrator, Regional Director of Operations, Regional Clinical Director and Medical Director) met on [DATE], at 5:00 PM to review the F678 IJ (Immediate Jeopardy). -The Facility created a Quality Assurance audit tool to be implemented on [DATE], used by the DON (Director of Nursing)/Designee, for all Licensed Nurses, for Medical Emergency Response. The Audit will be done with every nurse and then twice weekly with random nurses for three months. The results of the Audits will be reviewed with the QA (Quality Assurance) Committee at their monthly meetings. -The Facility created a QA audit tool to be used by Social Service/designee daily to assess all new admissions and readmissions for Code Status and or POLST orders, care plan and update the list of resident code status. The audit tool will be done daily for one month, then monthly for 3 months and then quarterly for a year. The audit tool to be implemented on [DATE].

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on record review and interview the facility failed to further assess a resident for changes in breathing and notify resident's physician. This applies to 1 of 3 residents (R55) discharged records reviewed in the sample of 20. The findings include: The admission record showed R55 was admitted to the facility on [DATE], with diagnoses of fracture of the right femur subsequent encounter for closed fracture with routine healing, hypopituitarism, type 2 diabetes, chronic diastolic congestive heart failure, obstructive sleep apnea and cerebral infarction due to embolism of the cerebral artery. On April 16, 2025, at 2:10 PM, V11 (RN) stated during the overnight shift of January 30-31, 2025, V11 was R55's nurse. V11 stated during the first rounds between 10:30 PM and 11:00 PM, V11 observed R55 sleeping on his side with regular respirations. V11 stated the next time she did rounds was between 2:30 AM and 3:00 AM, she observed R55 appeared to be sleeping, but was making coughing type noises while breathing. V11 stated she did not further assess R55 at that time. There is no documentation in R55's progress note of January 31, 2025, of V11's observations regarding R55's change in breathing. On April 16, 2025, at 5:40 PM, V12 (Medical Director) stated if a nurse observes a change in a resident's breathing, a further assessment should be done, especially a resident new to the facility. V12 stated an assessment should be documented in the medical record and report new findings to the physician. The facility's policy titled Notification of Changes, dated September 2024, showed Compliance guidelines: the facility must .consult with the resident's physician when there is a change requiring such notification . Circumstances that require notification include: .3. Circumstances that require a need to alter treatment. This may include: a. new treatment .

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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** 29562 Based on observation, interview, and record review, the facility failed to ensure that a resident's indwelling urinary catheter was secured. This applies to 1 out of 2 residents (R51) reviewed for catheter care in the sample of 20. The findings include: Face sheet shows that R51 is [AGE] years-old who has medical diagnoses including urinary tract infection (UTI). R51 was admitted to the facility on [DATE]. Minimum Data Set, dated dated dated [DATE], shows R51 requires assistance with toileting and hygiene. On April 15, 2025, at 1:05 PM, R51 was in the dining room sitting in her wheelchair in the dining room. R51 was actively moving in her wheelchair and had an indwelling urinary catheter bag handing under her wheelchair seat. R51 was able to respond to yes or no question, however, she was unable to coherently answer questions that needs explanation. V15 (CNA) stated that R51 was confused. On April 16, 2025, at 1:39 PM, V15 and V22 (Both Certified Nursing Assistants/CNA) rendered peri-care and catheter care to R51. The catheter tube was not secured to R51 and was hanging loosely. V15 and V22 did not attempt to secure or apply security device for R51's urinary catheter. On April 16, 2025, 1:51 PM, V8 (Nurse/RN) stated that indwelling urinary catheter must be always secured to the resident to prevent pulling of the catheter and prevent dislodging, and potential infection. On April 17, 2025, at 3:07 PM, V2 (Corporate Nurse) stated the urinary catheter should be secured or anchored to the resident to prevent any trauma and to ensure placement of indwelling urinary catheter.

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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. 36567 Based on observation, interview and record review, the facility failed to provide double portions of protein to a resident with weight loss. This applies to 1 out of 3 residents (R41) reviewed for nutrition in the sample of 20. The findings include: R41's EMR (electronic medical records) included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, end stage heart failure, gastro-esophageal reflux disease without esophagitis, chronic kidney disease, stage 3 unspecified. R41's quarterly MDS (minimum data set) dated January 20, 2025 showed that R41 was cognitively intact. R41's diet order on POS (Physician Order Sheet) showed General diet, Mechanical Soft texture, Regular/Thin consistency, Double proteins at each meal for Nutritional health (revised March 20, 2025), Offer Super Cereal with breakfast (revised March 27, 2025). R41's weight history recorded in lbs (pounds) in EMR included as follows: 148.4 lbs (March 1, 2025) 153.2 lbs (February 1, 2025) 158.4 lbs (January 1, 2025) 169.2 lbs (December 1, 2024) 163.0 lbs (November 1, 2024) 161.4 lbs (October 1, 2024) 161.4 lbs (September 1, 2024) Dietitian Weight Change Note dated March 14, 2025 included the following in summary with pertinent information: R41 with continued gradual weight loss after initial significant weight loss. Weight loss of 12.3% times 3 months, 20.8 lbs. Diet: General diet, Mechanical Soft texture, Regular/Thin consistency. R41 on Hospice care- comfort measure in place. Current body weight 148.4 lbs, Ht: 67 inches, Body Mass Index 23.2. Intake: overall good at 75-100% meals. Recommend to offer super cereal in the morning. Dietitian to follow up as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 15, 2025 at 10:18 AM, R41 stated I lost about 4 lbs as I got Prostate cancer. They haven't given me supplements. I would like some. On April 16, 2025 at 11:40 PM, R41 stated that he only receives one portion at meals. R41 stated When ever I ask for more portions they say that I can't have it. R41 patted his frame and stated I could really use it. R41 stated that he receives grits at breakfast. On April 16, 2025 at 12:12 PM, during lunch meal service at tray line, R41 received ground bratwurst served with a #10 scoop in a bun with cooked peppers and onions and a side order of tater tots, ice cream for dessert. R41's diet card only showed Dental soft, mechanical soft, super grits (for breakfast). The diet spread sheet (Week 4, Wednesday) for lunch included (one) portion size for ground bratwurst as #10 scoop with bun. Portion control chart showed that #10 =3 ounces. On April 16, 2025 at 12:14 PM, when V4 (Dietary Manager) was asked why R41 only received one portion of bratwurst when his diet order showed double protein, V4 stated that R41's diet card only shows one portion. V4 later added that he was not notified that R41 should have double protein portions. On April 17, 225 at 2:44 PM, V17 (Dietitian) stated that when she wrote (above referred) progress note, she only added supercereal. On checking the order on POS, V17 stated that the recommendation for double portions came from nursing and should have been implemented if its a diet order. V17 stated that after the order for double protein was added on the POS she is not aware of what happened after that. V17 stated that R 41 could use the extra calories with double protein as he has weight loss and more so if resident is asking for it. On April 18, 2025 at 12:57 PM, V24 (Regional Director of Operations) stated that facility does not have a policy and procedure on how a diet order change notification to dietary is made. R41's care plan revised September 23, 2024 included that R41 has nutritional potential nutritional problem related to cancer of prostate with metastasis to bone. Interventions included to provide and serve diet as ordered, provide and serve supplements as ordered.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 29562 Based on observation, interview, and record review, the facility failed to ensure that the insertion site of a resident's midline catheter is visible under a transparent dressing for assessment and failed to ensure that the central IV dressing was clean and intact. This applies to 1 of 2 residents (R158) reviewed for intravenous (IV) catheter in the sample of 20. The findings include: Medication Administration Record (MAR) dated April 2025, shows R158 receives Vancomycin HCL Intravenous Solution 1 gram (gm) twice a day and Ampicillin- Sulbactam Sodium Intravenous Solution 3 gm every 8 hours for osteomyelitis. On April 15, 2025, at 11:14 AM, R158 was resting in bed he was alert and oriented upon interview and was able to respond well to questions. R158 stated that he had a recent amputation of the right big toe due to osteomyelitis. R158 has a midline catheter dressing in the left arm. The insertion site was covered with gauze dressing that was soiled with dry blood. There was a transparent dressing on top of the gauze dressing. The edges of the transparent dressing were stained with black substances and was wrinkly and somewhat loose at the bottom. R158 stated that the dressing was changed sometime last week, but he was unable to recall the exact date it was done. On April 16, 2025, at 1:34 PM, R158 remained with the same soiled IV dressing, with insertion site not visible for assessment. Physician Order Summary (POS) dated April 1, 2025, shows to change midline dressing every Monday night for prophylaxis. On April 17, 2025, at 1:10 PM, V19 (Nurse/RN) attempted to measure the IV line from the insertion site to the tip of the catheter. V19 approximately measured the length of the catheter as 14 cm (centimeter) and she measured the arm circumference as 12 inches (30.48 cm). V19 stated that it's hard to get accurate measurement because the insertion site was covered with gauze and not visible. R158's midline should be covered with transparent dressing for accurate assessment. V19 also said the midline dressing should be change weekly and as needed when it is soiled to prevent infection and ensure cleanliness of IV site. On April 17, 2025, at 3:19 PM, V2 (Consultant Nurse) stated that midline catheter insertion site should be visible for assessment and measurements. The Medication Administration Record (MAR) dated April 2025, shows to measure R158's arm circumference and the IV line from the insertion site to the port every shift. The MAR documented 15 cm every shift. However, there was no measurement for the arm circumference, and there was no evidence of documentation of when the IV dressing was changed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of documentation in the progress notes about the arm circumference of R158, though there was documentation of length of catheter in the MAR, it was questionable about its accuracy because the insertion site was not visible under the gauze. R158's care plan for intravenous (IV) access device dated April 1, 2025, shows interventions including to check cannula site for signs of infiltration, dislodgement or infection and to monitor IV site for signs and symptoms of infection or indication of pain, infiltration, swelling, redness, the skin surrounding the insertion site is cool to touch. However, the IV insertion site and its immediate surrounding was covered with gauze, and not visible for accurate assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview and record review the facility failed to ensure that the physician's order for oxygen administration was followed. The facility also failed to ensure that the oxygen tubing and nebulization tubing were changed and labeled per facility policy. This applies to 2 of 2 residents (R2 and R53) reviewed for oxygen therapy in the sample of 20. The findings include: 1. R2 had multiple diagnoses including COPD (chronic obstructive pulmonary disease) and chronic respiratory failure with hypoxia, based on the face sheet. R2's annual MDS (minimum data set) dated March 10, 2025 showed that the resident was moderately impaired with cognition and required moderate to maximum assistance with most of her ADLs (activities of daily living). On April 15, 2025 at 10:35 AM, R2 was in bed, alert and oriented. R2 had an ongoing oxygen via nasal cannula at 5 liters per minute, using an oxygen concentrator. R2 denied having shortness of breath. R2's oxygen tubing and humidifier bottle was not labeled to indicate the date it was changed. V8 (RN (Registered Nurse) was present in the room and readjusted the oxygen setting to 3 liters per minute. According to V8, R2 should be at 3 liters per minute and not 5 liters. R2's active order summary report showed an order dated May 15, 2024 for, oxygen 2-4 liters per nasal cannula PRN (as needed) to keep oxygen saturation at 93% or greater. R2's active care plan initiated on August 8, 2020 showed that the resident had altered respiratory status and occasionally had difficulty breathing related to diagnoses of COPD and asthma. The same care plan showed multiple interventions including, changing and labeling of the oxygen tubing weekly while in use and oxygen via nasal cannula at 3 liters per minute PRN to keep oxygen saturation at 93% or higher. R2's MAR (medication administration record), TAR (treatment administration record) and progress notes for the month of April 2025 showed no documentation with regards to the weekly changing and labeling of the resident's oxygen tubing. On April 16, 2025 at 1:36 PM, V2 (Corporate Nurse) was informed that on April 15, 2025 at 10:35 AM, R2's oxygen level was observed at 5 liters per minute and the nasal cannula tubing had no label to determine when the tubing was changed. V2 was also informed that based on R2's care plan, the nasal cannula should be changed and labeled weekly while in use. According to V2, R2's physician order should be followed with regards to the amount of oxygen to be administered. V2 further stated that if the care plan indicated that the nasal cannula should be changed and labeled weekly, it should be performed because it is part of R2's oxygen care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy regarding oxygen administration last reviewed by the facility in January 2025 showed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy showed in-part under explanation and compliance guidelines, 5.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.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. 43389 2. R53's electronic medical record showed R53 is a [AGE] year old admitted to the facility on [DATE] with diagnoses that includes acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and Type 2 Diabetes Mellitus. R53 has a physician order dated January 23, 2025 that showed R53 should have continuous oxygen at 2-3 liters via nasal cannula or mask. On April 15, 2025 at 10:55 AM, R53 was receiving 3 liters of oxygen via nasal cannula. R53 stated the facility has not changed his nasal cannula in at least 2 weeks. R53 nasal cannula tubing was not dated. R53 stated his nebulizer tubing had not been changed in over a week. R53's nebulizer tubing was not dated.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 16746 Based on observation, interview and record review the facility failed to ensure that an RN (Registered Nurse) was assigned to serve as a full time DON (Director of Nursing) to coordinate nursing care and supervision, to provide quality care to residents. This applies to all the 52 residents that reside at the facility. The findings include: The facility's CMS (Centers for Medicare & Medicaid Services) 671 (Long Term Care facility application for Medicare and Medicaid) dated April 15, 2025 showed the total resident at the facility was 52. On April 15, 2025 at 1:17 PM, V2 (Corporate Nurse) stated that the facility's designated DON had resigned, and she (V2) comes to the facility on ce a week, since the DON left. On April 17, 2025 at 2:15 PM, V1 (Administrator) stated that he received a text message from V14 (RN/former DON) on April 4, 2025 stating that she was not coming in the facility that day and that she (V14) will be sending an official letter of resignation by the end of the day. V14 stated that on April 7, 2025 he received a call from V14, informing him that she will be resigning effective May 2, 2025 and will be sending her resignation letter. According to V1, V14 never came to report to the facility from April 4 to the current (April 17, 2025) to perform her duties. V1 stated that the facility has not heard from V14 and have not received any letter of resignation from her (V14). V1 believes that V14 will not be coming back to work at the facility, so he went ahead and hired a new DON. V1 acknowledged that the facility does not have a full time DON from April 4 until the newly hired DON starts on April 22, 2025. During the entire survey from April 15 through April 18, 2025, the facility did not have a designated RN to serve as the DON (Director of Nursing). During this survey deficient practice were identified on the following areas: ADL (activities of daily living) care, urinary catheter care, IV (intravenous) care, oxygen therapy and care, labeling of medications, controlled medication inventory and storage, addressing pharmacy recommendations, infection control surveillance, advance directive, and development of care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 29562 Based on observation, interview, and record review the facility failed to ensure accurate and timely accounting of controlled medications and failed to ensure that narcotic medication was stored in a sealed packaging. This applies to 4 of 4 residents (R2, R28, R37, R47) reviewed for controlled medications in the sample of 20. The findings include: On April 15, 2025, at 5:45 PM, the controlled medication was counted with V7 (Nurse/LPN), and the following were observed: 1. R37's blister pack of Tramadol HCl 50 mg (milligrams) number 8 and number 16 tablets, the seal of the packagings were broken. 2. R47's blister pack of Oxycodone 50 mg with 19 tablets remaining that were intact and sealed. R47's controlled drug receipt/record/disposition form for the Oxycodone showed that there should be 20 remaining in the blister pack. V7 stated that she gave the Oxycodone tablet to R47 earlier and has not signed it out yet. 3. R28's blister pack of Alprazolam 0.25 mg with 3 tablets left that were intact and sealed. R28's controlled drug receipt/record/disposition form for the Alprazolam showed that there should be 4 tablets remaining in the blister pack. V7 stated that she gave the Alprazolam tablet to R28 earlier and has not signed it out yet. 4. R2's blister pack of Phenobarbital 64.8 mg with 12 tablets left that were intact and sealed. R2's controlled drug receipt/record/disposition form for the Phenobarbital showed that there should be 13 tablets remaining in the blister pack. V7 stated that she gave the Phenobarbital tablet to R2 earlier and has not signed it out yet. On April 17, 2025, at 2:52 PM, V2 (Corporate Nurse) stated the nurse must document in the MAR (Medication Administration Record) and sign out the controlled medication from the controlled drug receipt/record/disposition form as soon as the medication was given to the resident. This was according to the facility's policy and for accuracy of record. If the seal is broken from the blister pack of the controlled medication, the medication should be disposed with a secondary nurse as a witness, to prevent drug discrepancy or unlawful drug diversion. Facility's Policy and Procedure for Controlled Substance Administration and Accountability dated May 2024, shows: Policy: 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 to prevent loss, diversion, or accidental exposure. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: g. In all cases, the dose noted on the usage form or entered to the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389 Based on interview and record review the facility failed to address resident pharmacy medication regime review (MRR) recommendations. This applies to 2 of 5 residents (R31 and R28) reviewed for unnecessary medications in the sample 20. The Findings include: 1. R31's electronic medical record showed R31 is a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, malignant neoplasm of the larynx, tracheostomy, chronic respiratory failure with hypoxia and hypercapnia, hypertensive heart disease with heart failure and morbid obesity. R31 had the following active orders as of April 17, 2025 at 12:26 PM: 1) Lorazepam 0.5 milligrams, 1 tablet every eight hours as needed for anxiety and the order was dated November 10, 2022 2) Guaifenesin Extended Release 12 Hour 600 MG (guaifenesin ER) 1 tab in the morning, and 2 tabs at night, and the order was dated November 18, 2022. 3) Guaifenesin Tablet Extended Release 12 Hour 600 MG (guaifenesin ER) 1 tab in the morning, and 2 tabs at night, and the order was dated November 18, 2022. R31's pharmacy MRR sheets for the last six months were reviewed and included the following: a) The pharmacist MRR's dated October 15, 2024, November 18, 2024, January 21, 2024, February 18, 2025, March 18, 2025 stated the following: Per Centers for Medicare and Medicaid services regulations, as needed psychotropic order(s) are limited to a 14 day duration. An as needed order may continue past 14 day if a clinical rationale for administration on an as need basis is documented within the residents chart. b) The pharmacist MRR's dated December 17, 2024 and February 18, 2025 showed the following: R31 had been receiving Guaifenesin extended release 600 milligrams every morning and 1200 milligrams every night since November 2022. Please assess if continued scheduled treatment is still necessary. Please consider discontinuation or reduction to an as needed basis for congestion. On April 17, 2025 at 12:26 PM, V8 (Registered Nurse) stated she has not given R31 Lorazepam in a very long time. V8 looked up R31's last administration of Lorazepam on her computer. V8 stated R31's last dose of Lorazepam was May 13, 2024. V8 looked in her control substance locked drawer to see if R31 had any Lorazepam after May 13, 2024, and R31 did not receive any. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R31 electronic medication administration record showed that R31 had not been administered Lorazepam in the last 6 months, however, R31 had been given guaifenesin ER twice per day. 2. R28's electronic medical record showed that R28 was admitted to the facility on [DATE] with diagnoses that includes vascular dementia with behavioral disturbances, cerebral infarction, schizoaffective disorder depressive type, anxiety disorder, and major depressive disorder. R28's pharmacy MRR sheets for the last six months were reviewed and included the following recommendations: a) The pharmacist MRR dated February 18, 2025 stated Resident is receiving Depakote 500 MG daily and 250 mg every evening. I was unable to locate a recent valproic acid level within his lab records. Please assess if obtaining a valproic acid level with a future blood draw would be beneficial. b) Review of recent labs drawn in January found a slightly reduced vitamin D level. Resident is not currently receiving a vitamin D supplement. Please assess if starting Vitamin D 1000 units daily would be beneficial and/or ordering a follow-up vitamin D level would be appropriate. All of the pharmacy MRR recommendation forms mentioned above were blank and were not signed off by the attending physician to show that the recommendations were reviewed. There was no documentation presented that showed the pharmacy recommendations were addressed. On April 18, 2024 at 2:03 PM, V2's (Corporate Nurse) voicemail was full and was not able to leave a message or contact V2 for interview. On April 18, 2025 at 8:30 AM, V1 (Administrator) stated that V2 (Corporate Nurse) is the person that receives the medication regimen review recommendations from the pharmacy. On April 18, 2025 at 4:25 PM, V1 stated he was not able to reach V2 either as her voicemail box was full. The facility's MRR policy dated January 2025 stated the pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation. The facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 29562 Based on observation, interview, and record review, the facility failed to label medication for the date it was opened to determine expiration date. This applies to 4 of 5 residents (R2, R8, R37, R49) reviewed for labeling and storage in the sample of 20. The findings Include: On April 15, 2025, at 5:29 PM, the unit 2 medication cart was inspected with V7 (Nurse), and the following were observed: 1. R2's Incruse Ellipta was opened and not dated. The manufacturer's recommendation shows to safely throw away Incruse Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label of the inhaler. 2. R37's Insulin Lispro was opened and not dated. The pharmacy list for expiration date shows that this medication expires 28 days after first use or removal from refrigerator. 3. R49's Insulin Lantus was opened and not dated. The pharmacy list for expiration date shows that this medication expires 28 days after first use or removal from refrigerator 4. R8's Fluticasone Furoate/Vilanterol Ellipta Inhalation Powder was opened and not dated. The manufacturer's recommendation shows to safely throw away BREO in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label of the inhaler. On April 17, 2025, at 2:56 PM, V2 (Corporate Nurse) stated that the medications mentioned above should be dated upon opening to determine the expiration dates.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 36567 Based on observations, interview and record review, the facility failed to provide modified diet consistency for residents on thickened consistency liquids. This applies to 2 of 2 residents (R28, R24) reviewed for thickened liquids in the sample of 20. The findings include: 1. R24's face sheet included diagnoses of Parkinson's disease without dyskinesia, without mention of fluctuations, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, dysphagia, unspecified. R24's POS (Physician Order Summary) showed General diet, General diet, Pureed texture, Nectar consistency (revised October 17, 2023). On April 16, 2025 at 11:46 AM, during tray line service at the lunch meal R24 received a pureed diet with nectar thickened beverages in glasses and also received a bowl of ice cream in addition to other nutritionally enhanced supplements. R24's meal ticket showed Pureed texture, mildly thick nectar thick liquids. R24's dietary care plan updated on October 14, 2023 included that R24's appetite has decreased, continue pureed/nectar thick liquids . 2. R28's face sheet included diagnoses of cerebral infarction, unspecified, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia with behavioral disturbance, dysphagia, oropharyngeal phase, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, aphasia. R28's POS showed General diet, Pureed texture, Honey consistency for 1:1 feed, may eat all meals while up (order date May 12, 2021). R28's current care plan included that R28 has a swallowing problem related to stroke, is receiving Pureed diet with honey thick liquids. Interventions included that diet to be followed as prescribed. On April 16, 2025 at 11:46 AM, during tray line service at the lunch meal R28 received a pureed diet with honey thickened beverages in glasses, 4 oz/ounce portion of mighty shake (nutrition health shake) and also received a bowl of ice cream. R28's meal ticket showed Pureed diet, honey thick liquids. When V4 (Dietary Manager), who was in the vicinity, was asked if the consistency of mighty shake was honey thick, and whether ice cream was suitable for thickened liquids, V4 responded to my knowledge it's (ice cream) pretty thick and the (mighty) shake is already thickened. V4 stated that he added milk to the ice cream. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 17, 2025 at 10:28 AM, V18 (Speech Language Pathologist) stated that residents on thickened liquids cannot have ice cream as it starts of as a solid form and eventually melts to thin liquids. V18 stated that mighty shake is nectar thick and not honey thick consistency. V18 added that the facility would have to add more thickener to this mighty shake to obtain the honey thick consistency. Facility policy on Consistency Altered Diets taken from Simplified Diet Manual (Twelfth Edition, 2016) included as follows for Liquid Consistency Levels: Liquids that change thickness at room temperature or body temperature may not be appropriate for persons on thickened liquids. Examples include milkshakes, ice cream, sherbet, frozen yogurt, and gelatin. A variety of commercial thickeners are available to modify liquids' consistencies. Follow the manufacturer's direction to achieve the preferred thickness.

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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. 36567 Based on observation, interview and record review, the facility failed to follow sanitary practices in the facility kitchen. This applies to all 52 residents that received foods prepared in the facility kitchen. The findings include: Facility's CMS Form 671 dated April 15, 2025 showed that the facility census was 52 residents. Facility provided information that there were no residents on NPO (nothing by mouth) status. On April 15, 2025 at 09:20 AM, the initial tour of facility kitchen was done in presence of V4 (Dietary Manager). The hand sink area had unknown grime and had 2 scrub pads inside the sink that appeared to be used to prewash dishes at the dish machine. When questioned why the hand sink area was soiled, V4 stated that they do not have enough space in the kitchen to manage all tasks. The reach in, two door steel refrigerator in the kitchen had marked grime and unknown smears on the handle and the surface of the refrigerator. V5 (Cook) and V4 were seen opening and closing the refrigerator during meal prep and or service. There was a large pan inside the top shelf of the refrigerator which was half full of stagnant water. V4 stated that there was a leak in the refrigerator and the pan was placed to catch the drips of water. V4 added that it was the same problem that was identified in the last year annual survey and it was never fixed. A drawer at the prep station near the stove that stored utensils used for cooking, had grime and dust. The surface areas on shelves beneath the center workstation that stored multiple inverted pans also had food debris, dust and unknown grime. The ice scoop used to scoop ice from the ice machine was placed on workstation that had dust and unknown debris. V4 stated Does it (ice scoop) have to be covered. I don't remember. During the tour V4 was also notified of the above unsanitary surfaces. On April 15, 2025 at 11:40 AM, V6 LPN (Licensed Practical Nurse) was seen coming into the kitchen and taking the scoop from the workstation and get ice from the ice machine V6 did not wash her hands or wear gloves. V6 stated that she is getting the ice to add it into the water pitcher on her medication cart as some residents like cold water. On April 15, 2025 at 11:43 AM, prior to start of meal service, V5 (Cook) was requested to take the food temperatures. The pureed spaghetti and pureed garlic bread both showed 120 degrees Fahrenheit respectively. V4 had to be prompted to reheat the items prior to serving the same. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On April 17, 2025 at 2:44 PM, V17 (Dietitian) stated that the food prep and refrigerator door surface area should be clean for sanitary purposes. V17 stated that staff coming from outside the kitchen should wash their hands prior to getting ice from the ice machine and that the ice scoop should be in a scoop holder. V17 stated that hot foods at the steam table should be at minimum 135 degrees Fahrenheit. Facility policy and procedure taken from 'Guideline & Procedure Manual 2020' included as follows: Storing Utensils, Tableware, and Equipment- Guideline: Employees will store utensils, tableware and equipment according to the following guideline Procedure: 2. Food contact surfaces of fixed equipment should be protected from contamination by splash, dust or other means. 3. Clean and sanitize drawers and shelves before clean items are stored. Ice Handling and Cleaning: Guideline: Ice will be stored and served to residents in a sanitary manner. Procedure: 1. Ice will be handled, transported and stored to protect against contamination. 3. Ice buckets, other designated containers, and scoops will be kept clean and sanitized. Scoops will be stored in a protected manner . Monitoring Food Temperatures for meal Service: Guideline: Food temperatures will be monitored to prevent foodborne illness and to ensure foods are served at palatable temperatures. Procedure: 3d. If the serving holding temperature of hot food item is not at 135 degrees Fahrenheit or higher, when checked prior to meals service, the item will be reheated to at least 165 degrees Fahrenheit for a minimum of 15 seconds.

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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** 36567 Based on observations, interview and record review, the facility failed to ensure that the resident refrigerators in the room are maintained in safe and sanitary manner. This applies to 2 of 2 residents (R36, R43) reviewed for personal food storage in the sample of 20. The findings include: On [DATE] at 11:12 AM, R43's room had a refrigerator near her bed. R43 spoke primarily in Spanish and R43 was notified that the temperature of her refrigerator was going to be checked. The refrigerator contained multiple cans of soda, bags of (few) grapes in each bag, a tub of cream cheese, a bottle of salsa, salad dressing and sweet and sour sauce with use by date [DATE]. There was no thermometer inside the refrigerator and no temperature logs were seen. R43 then motioned that this refrigerator belongs to her roommate R36, who was not in the room. R43 pointed to another refrigerator in the corner of the room near the foot of her bed and stated that is the refrigerator that belonged to her. With R43's permission, her refrigerator was also checked and noted to have multiple items including four food storage (plastic) containers of unknown prepared foods which were unlabeled with dates brought in. R43 stated that her family brings the foods. The refrigerator also had 2 cartons of milk, one unopened and the other one almost empty. R43's refrigerator also did not have a thermometer and no temperature logs were seen. On [DATE] at 11:19 AM, V15 (Certified Nursing Assistant), who was in the vicinity, when asked stated that she doesn't know who checks the refrigerator and remarked Maybe the Maintenance. On [DATE] at 9:46 AM, V16 (Housekeeping Director) stated I am in charge of the refrigerators in resident rooms. I check once a month for expired stuff and throw it out. We don't check the temperatures. My department also cleans it (refrigerators) out once a month. Facility policy and procedure titled Use and Storage of Food brought in by Family or Visitors (dated [DATE]) included as follows: Policy: It is the right of the residents of this facility to have food brought in by family or other visitors , however, the food must be handled in a way to ensure the safety of the residents. Policy Explanation and Compliance Guidelines: 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. b. The prepared food must be consumed by the resident within 3 days. c. If it is not consumed by the resident in 3 days, food will be thrown out by the facility staff. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. The facility staff will assist residents in accessing and consuming food that is brought in by resident and family or visitor if the resident is not able to do so on their own. Facility policy and procedure titled Refrigerators in Resident Rooms (Manual 2000) included as follows: Procedure: 1. The Housekeeping Department will keep a current list of rooms with resident refrigerators. 2. Each refrigerator shall have a thermometer log with daily entry. Each refrigerator will have an inside thermometer. The refrigerator temperature will be maintained at or below 41 degrees Fahrenheit. If the temperature is not maintained at 41 degrees Fahrenheit or below, the food will be discarded. 3. The housekeeper will enter the temperature once daily. Any temperature not in range will be immediately reported to the Housekeeping Supervisor or Nursing Supervisor and Maintenance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48308 Based on observation, interview and record review, the facility failed to provide hand hygiene during medication administration, failed to use PPE (Personal Protective Equipment) while providing direct care for a resident on EBP (Enhanced Barrier Precautions) and failed to do complete infection control surveillance monitoring for the facility. This applies to all 52 residents who reside in the facility. The Findings include: Facility's CMS Form 671 dated April 15, 2025 showed that the facility census was 52 residents. 1 On April 17, 2025, at 2:50 PM, V1(Administrator) stated V3 (MDS Nurse) was in the role of IP (Infection Preventionist) but was not trained. V3 was not in the facility and unavailable for interview. V1 provided the infection prevention surveillance documentation for January, February and March 2025, and V1 stated there was no infection surveillance the month of April 2025, and no residents who required TBP (Transmission Based Precautions). V1 provided the Infection Log the facility utilizes for tracking infection. The Infection Log included a column for documentation for the following: Unit, Date, Resident, Room #, Site, Organism, Lab/Culture, Antibiotic, Isolation/Precautions, Symptoms present on admission, and Acquired in Facility (HAI). The total resident days per month and the infection incidence rate for the month were at the top of the form to complete the documentation. The Infection Log dated January 2025, showed missing data and no infection Incidence rate. There were 12 residents listed on the infection log. The log showed 9/12 residents missing the Site of the infection, 6/12 residents missing the Organism, 12/12 did not specify if any Lab/Culture results were completed, 10/12 did not identify if symptoms were present, if isolation precautions were needed, or if the infection was acquired in the facility or was community acquired. The Infection Log dated February 2025, showed missing data and no infection incidence rate. There were 7 residents listed on the infection log. The log showed: 7 of 7 residents listed, had no data entered for Site, Isolation/Precautions, Symptoms, Labs/Cultures or if Acquired in the facility. The Infection Log dated March 2025, showed incomplete data and no infection incidence rate. There were 12 residents listed on the infection log. The log showed: 7 of 12 residents did not have the Site recorded or if Facility Acquired, 8 of 12 residents did not specify if Labs/Culture was done or if Symptoms were present, and 9 of 12 had no data for Isolation /Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's policy titled Infection Surveillance dated August 2024, showed Policy: A system of infection surveillance serves as the core activity of the facility's infection prevention and control program .5. Surveillance activities will be monitored facility-wide, and may be broken down by department or unit depending on the measure observed. A combination of process and outcome measures will be utilized .6. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: a. Data to be collected .i. the infection site, pathogen (if available), signs and symptoms, and resident location including summary and analysis of the number of residents (and staff) who developed infections .9. All resident and infections will be tracked. 29562 2. Face sheet shows that R44 has multiple medical diagnoses including paraplegia, urinary tract infection, neuromuscular dysfunction of bladder. Care plan report shows that R44 has indwelling urinary catheter, intravenous catheter, and R44 was placed on Enhance Barrier Precaution (EBP). On April 15, 2025, at 10:27 AM, V15 and V23 (Both Certified Nursing Assistant/CNA) provided morning care to R44. V15 and V23 donned gloves while providing care to R44. They provided peri-care, emptied catheter bag, applied petroleum jelly to R44's legs and thighs, and transferred R44 via mechanical lift from bed to wheelchair. Though they changed gloves and sanitized hands in between tasks, they did not wear an isolation gown throughout the care. Enhance Barrier Precautions (EBP) shows Providers and Staff must also wear gloves and a gown for the following High-Contact Resident Care Activities such transferring, changing briefs or assisting with toileting, device care or use central line, urinary catheter, feeding tube, and tracheostomy. 3. On April 15, 2025, at 4:07 PM, V7 (Nurse) administer medications to R49, then she donned a pair of gloves to checked R49's blood glucose. After getting the glucose level and while wearing same gloves, she went back to the medication cart and documented R49's glucose in the computer. V7 continued to open the medication drawer to get the BP (blood pressure) apparatus. V7 removed her gloves and checked R49's BP. V7 returned to the cart and opened the drawer to get cell phone to call the NP (Nurse Practitioner). V7 did all these different tasks from the dirty to clean and did not perform hand hygiene during R49's medication administration and assessments. 4. On April 15, 2025, at 4:26 PM, V21 (Nurse/RN) prepared and attempted to administer medications to R36. When R36 refused the medications, V21 started to prepare the medication of R43. At 4:33 PM, V21 adjusted the Oxygen tube of R43 with her bare hands, then she donned gloves and check the blood glucose level. V21 removed her gloves and without hand hygiene, left R43's bedroom to administer medication to another resident (R5) who was asking her for a pain reliever. After V21 gave the pain reliever to R5, V21 returned to R43's bedroom to continue to give the nebulizing treatment. V21 did all the different tasks and assisted different residents without performing hand hygiene in between tasks and residents. On April 17, 2025, at 3:09 PM, V2 (Corporate Nurse) stated the nurses must perform hygiene before and after resident care, in between tasks and in between residents, regardless of wearing gloves. Gloves are not a substitute for hand hygiene for infection control. Whenever the staff is providing hands on care to resident who is identified under enhance barrier precaution, the nurse must wear complete personal protective equipment such as gown and gloves as part of infection prevention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Aurora	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility's Hand Hygiene Policy and Procedure dated October 2023, shows: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working within the facility. Policy Explanation and Compliance Guidelines shows: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 48308 Based on interview and record review the facility had incomplete documentation on the Antibiotic Surveillance log and failed to evaluate the presence of infection utilizing the standardized criteria to define infections, in accordance with facility policy. This applies to all 52 residents who reside in the facility. The Findings include: On April 17, 2025, at 2:50 PM V1 (Administrator) stated he was unsure if the facility utilizes McGeer criteria or any criteria for evaluating the use of antibiotics. V1 provided Antibiotic Surveillance Log for the months of January, February and March 2025. V1 stated there was no Antibiotic Surveillance Log for the month of April 2025. V1 stated V3 (MDS Nurse) was assigned the role of IP (Infection Preventionist) but was not trained and was not available for interview. Upon request for the documents related to the facility Antibiotic Stewardship program the facility provided the policy and 3 months of Antibiotic Surveillance Logs. The Antibiotic Surveillance Log had 8 columns for data to be entered. The columns were titled: Date, Resident, Room #, Antibiotic order, Diagnosis, Ordering Practitioner, Documentation Supports Necessity, and ordered upon admission. The Antibiotic Surveillance Log dated January 2025, showed 11 residents listed on the log. The log was incomplete. The log showed 4 of 11 residents did not have diagnosis for use of antibiotic, and 10 of 11 residents had no data in the columns for ordering Practitioner, Documentation supports necessity, and ordered upon admission. The Antibiotic Surveillance Log dated February 2025, showed 6 residents listed on the log. The log was incomplete. The log showed 1 of 6 residents did not have a diagnosis for antibiotic use, and 6 of 6 residents had no documentation for the columns for ordering Practitioner, Documentation Supports Necessity and Ordered upon admission. The Antibiotic Surveillance Log dated March 2025 showed 8 residents listed on the log. The log was incomplete. The log showed 3 of 8 residents did not have a diagnosis listed for use of antibiotic, and 8 of 8 residents did not have documentation for the column Documentation Supports Necessity. The Facility did not provide completed assessment forms to define infections (i.e. McGeers criteria, Loeb's Minimum criteria or NHSN surveillance definitions), antibiotic stewardship meeting minutes or records related to education of physicians, staff, residents and families as outlined in the facility policy. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled Antibiotic Stewardship Program dated January 2025, showed Policy: It is the policy of the facility to implement an Antibiotic Stewardship program as part of the facility's overall infection control program .4. The program includes antibiotic use protocols and a system to monitor antibiotic use .a. Antibiotic use protocols: iii. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections .iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics .9. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents and family.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48308 Based on interview and record review the facility failed to ensure that the facility's IP (Infection Preventionist) had completed specialized training in infection prevention and control. This applies to all 52 residents who reside in the facility. The findings include: On April 17, 2025, at 2:50 PM, V1 (Administrator) stated the facility's trained IP was the former Director of Nursing, who last worked in the facility on April 4, 2025. V1 stated V3 (MDS Nurse) was assigned the duties of the IP. V1 became Administrator on February 24, 2025, and stated V3 was already assigned the IP position. V1 stated currently there is no staff onsite who completed specialized training in Infection Control. V3 had not received any specialized training in infection control. V3 was not available to be interviewed during this investigation. The infection control surveillance tracking that V1 provided for January, February and March 2025, was incomplete. There was no infection control surveillance tracking for the month of April 2025. The in-service training provided by the facility on infection control topics, since the last annual survey was reviewed. The most recent infection control in-service provided for facility staff was provided by V14 (former DON) on December 30, 2024. There was no infection control in service training provided in 2025. The facility's policy titled Infection Surveillance dated August 2024, showed Policy Explanation and Compliance Guidelines: 1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective action made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required .6. The facility will collect data to properly identify possible communicable disease or infections among residents and staff before they spread by identifying: a. Data to be collected: i. The infection site, pathogen, signs and symptoms .including summary and analysis .ii. Observations of staff including the identification of ineffective practices .ii. The identification of .infection trends .8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends.