STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145944	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Aurora	400 West Sullivan Road 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the Long-Term Care Ombudsman facility representative of non-emergent transfer and discharges monthly as the agency requested. This applies to 4 of 4 residents (R9, R12, R88, R89) reviewed for discharge in the sample of 23. The findings include:1.R89's EMR (Electronic Medical Record) showed R89 was admitted to the facility on [DATE], and discharged on February 14, 2026. R89 was selected for closed record planned discharge review. On [DATE], at 11:41 AM, V28 (Social Services Assistant) stated R89 was discharged back to the community senior living apartment, where she resided previously. Requested evidence of notification of discharge to the Long-Term Care Ombudsman representative and V28 referred surveyor to V3 (Assistant Administrator).On [DATE], at 11:45 AM, V3 stated the notification to the ombudsman occurs through email notification. V3 provided email notification of R89's discharge that occurred on [DATE], at 11:43 AM. V3 stated the last notification of non-emergent transfer and discharges to the ombudsman office occurred on February 9, 2026, also through email, submitted by V1 (Administrator). V3 stated she was unsure how often the Ombudsman's office is notified of transfer and discharges, but the notification happens by running a report through the EMR. 2. R88's EMR showed R88 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy, unspecified dementia and hypertensive heart disease.R88 expired in the facility on [DATE], at 3:00 AM. R88's death certificate showed R88 expired due to cardiorespiratory arrest. The facility did not notify the ombudsman of the resident's death until [DATE], when surveyor requested to see ombudsman notification of discharge. 3. R9 was admitted to the facility on [DATE], and discharged to the hospital on [DATE].R9's discharge notification to the ombudsman did not occur until [DATE], when surveyor requested evidence of discharge notification to the ombudsman.R9 was readmitted to the facility on [DATE]. 4.R12's EMR showed admitted to the facility on [DATE], and discharged to the hospital on [DATE]. R12 had not yet returned to the facility.R12's transfer to the hospital notification to the ombudsman did not occur until [DATE]. The facility's report to the Ombudsman office, transfer/discharge report sent on [DATE], contained 74 records for discharge date s ranging from February 13, 2026, through [DATE]. On [DATE], 1:24 PM, V29 (Facility Ombudsman) stated the expectation is for facilities to send notification of non-emergent discharges and transfers to the ombudsman office monthly. V29 stated she just received a report from the facility today, [DATE], and prior to that had not received a report from the facility since February 9, 2026. The Facility was unable to provide a policy to address non emergent notification of transfer/discharge to the Ombudsman office.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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** Based on observation, interview and record review, the facility failed to provide grooming/hygiene for a resident who required assistance for ADL (Activities of Daily Living) care.This applies to 1 of 1 resident (R43) reviewed for ADL care in the sample of 23. The findings include:On May 11, 2026, at 11:47 AM, R43 was in bed. R43 had about 0.5 to one CM (centimeters) long facial mustache and chin hair. R43 said she doesn't like facial hair and would like to get it shaved, but she couldn't do it by herself.On May 12, 2026, at 11:21 AM, R43 was in bed and still had the same facial hair. R43 said she asked, but no one assisted her with shaving her facial hair. R43 said she forgot the name of the staff she asked to assist her with shaving her facial hair.On May 13, 2026, at 2:41 PM, R43 was in bed and still had the same facial hair. R43 said she asked one of the CNAs (Certified Nursing Assistants) to assist her with shaving her facial hair, but they still haven't done so.According to the EMR (Electronic Medical Records), R43 had multiple diagnoses including reduced mobility, other fatigue, other chronic pain, and vascular dementia, with unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.R43's Minimum Data Set, dated [DATE], showed R43 had mild cognitive impairment and was dependent on staff for shower, bathing, and personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.R43's Care Plan initiated on August 14, 2023, showed R43 had an ADL Self Care Deficit and Impaired Mobility due to impaired balance, weakness, and pain. The care plan interventions included that R43 required total assistance from staff with personal hygiene care. On May 12, 2026, at 12:13 PM, V2 (Director of Nursing) said the CNAs always ask residents if they want to be shaved, and if they do, the CNAs will do it for them. V2 said the CNAs shave the residents daily, every 3 days, as needed, and as requested by the residents. V2 said the CNAs are supposed to assist the residents with shaving as part of hygiene and grooming, and to support dignity.The facility's policy titled, General Care with a revision date of June 30, 2025, showed, Policy Statement - It is the facility's policy to provide care for every resident to meet their needs.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary assistance and supervision during toileting, for a resident that had limited ability to sit unsupported, was cognitively impaired, with known impulsivity, and at high risk for falls, to prevent a fall that resulted in injury. This applies to 1 of 2 residents (R9) reviewed for falls in the sample of 23. R9's EMR (Electronic Medical Record) showed R9 was readmitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non dominant side, kidney transplant status, type 2 diabetes, abnormal posture and hypertensive heart disease.R9's MDS (Minimum Data Set) dated April 23, 2026, showed R9 was severely cognitively impaired and required assistance with ADL's including supervision with eating and oral hygiene, substantial assistance with upper body dressing, bed mobility and transfer, and dependent on staff for toileting, bathing, and lower body dressing. R9's care plan initiated on March 13, 2026, for toilet use showed R9 required staff participation of 1 to assist with toileting and high risk for falls due to history of falls, gait deviations and poor safety awareness. R9's fall care plan interventions included to ensure staff keep call light within reach and respond promptly to requests.R9's Occupational Therapy Evaluation and Plan of Treatment dated April 17, 2026, showed R9 had left side flaccid paralysis and had poor sitting balance with inability to right himself during self-care activities and baseline assessment showed R9 was dependent on staff for toileting tasks.R9's fall risk assessment that was part of R9's readmission assessment, dated April 16, 2026, showed R9 had a fall at home prior to admission, and had a risk score of 8, indicating a high risk for falls. R9's incident report dated April 30, 2026, showed R9 had an unwitnessed fall while left unattended in the bathroom. The report showed in response to a loud thud, staff found R9 had fallen from the toilet onto the floor and was lying face down on the floor. The nurse called 911 and R9 was taken by ambulance to the hospital.R9's physician orders showed R9 received anticoagulant medication daily initiated on April 17, 2026.R9's physician progress note dated May 4, 2026, showed R9 sustained injury to left eye with significant periorbital edema, ecchymosis, and severe subconjunctival hemorrhage due to the unwitnessed fall.On May 13, 2026, at 12:15 PM, V2 (DON) stated he responded to the loud noise in R9's room on April 30, 2026, around breakfast time. V2 stated 911 was called when R9 was found lying on the floor in the bathroom with his head on the floor, because R9 was receiving anticoagulant medication. V2 stated the safest option for R9 while in the bathroom was for staff to remain with R9 to prevent fall due to R9's poor safety awareness and previous falls.On May 13, 2026, at 12:20 PM, V13 (CNA, Certified Nursing Assistant) stated she was R9's assigned CNA on the day shift on April 30, 2026. V13 stated she was serving breakfast trays when she entered R9's room with R9's tray and R9 requested to go to the bathroom. V13 stated she got assistance from V8 (CNA). V13 stated V8 assisted to transfer R9 from the bed to the wheelchair and from the wheelchair to the toilet. V13 stated both V13 and V8 left the room leaving R9 unattended on the toilet. V13 stated she then continued to distribute breakfast trays and had assisted the resident in the room next to R9's when she came out of that room and saw V14 (CNA) and V2 running into R9's room.On May 13, 2026, at 12:27 PM, V14 stated on the morning of April 30, 2026, around breakfast time, V14 was standing in the nurses' station when she heard a loud noise coming from R9's room. R9's room was located across from the nurses' station. V14 stated she ran to the room and V2 was also present and found R9 lying face down on the floor. V14 stated there was no staff in the room when she entered the room.On May 13, 2026, at 12:30 PM, V15 (PTA Physical Therapy Assistant) stated R9 required maximum assistance of 1 and perhaps 2 staff depending on how much R9 assists with the transfer. V15 stated R9 does not stand long and tends to be impulsive and lacks safety awareness. V15 stated R9 is encouraged to use the call light but is inconsistent using it. V15 stated R9 is weak and prefers to lay down. V15 stated even when R9 is seated he often extends his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feet and pushes forward in a movement that would result in sliding out of the chair. V15 stated due to R9's weakness, impulsivity, and lack of safety awareness, R9 would need to be supervised when in the bathroom. V15 stated R9s mobility has essentially not changed since admission, despite receiving therapy. V15 stated R9 is at high risk for falls.The facility's policy titled Fall Occurrence dated June 30, 2025, showed the policy of the facility is to ensure that residents are assessed for risk for falls, that interventions are put in place and revised as necessary and those that are identified as high risk for falls will be provided fall interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review the facility failed to perform a nutrition assessment and implement interventions for a resident experiencing poor appetite and oral intake, hyperkalemia, and significant weight loss. This applies to 1 of 1 residents (R1) reviewed for nutrition in a sample of 23. The findings include: Social Services progress note, dated May 11, 2026, shows R1's cognition was intact. Hospital nephrology note, dated April 9, 2026, shows R1 experienced hyponatremia, volume overload with edema, high blood potassium, acute kidney injury, and required temporary hemodialysis with her last dialysis treatment on April 2, 2026. Review of R1's Care Plan shows R1 was at risk alteration in nutritional status related to congestive heart failure and morbid obesity and approaches included monitoring for weight loss, obtaining and reporting abnormal labs, weigh as order, and provide diet as order. R1's fluid care plan showed R1 was at risk for adverse reactions related to dehydration or potential fluid deficit due to congestive heart failure, hypertension and diuretic use. The care plan shows R1 was to be encouraged to drink fluids of choice and monitor for signs of dehydration including weight loss, monitor labs as ordered and obtaining and monitoring weights as ordered by the physician. On May 11, 2026 at 11:10 AM, R1 stated she recently returned to the facility from the hospital after being admitted for low blood sodium levels. R1 stated she had no appetite, did not feel like eating, and had not talked to a dietitian at the facility about her poor oral intake. At 12:42 PM during lunch, R1 had no meal tray and stated she did not want to eat because her stomach was upset On May 12, 2026 at12:08 PM just prior to lunch being served, R1 stated she was not hungry and stated she did not eat breakfast earlier that morning. R1 stated staff offered her an oral supplement that morning which was the first time R1 was offered a supplement while at the facility. R1 stated her appetite was very poor, was losing weight at home for a few months prior to coming the facility, and stated if she did not eat a meal at home she would drink two oral nutritional supplements to try to prevent weight loss. R1 stated she enjoyed hot dogs, lunch meat, and chili. At 12:15 PM, V24 (CNA- Certified Nursing Assistant) and V22 (CNA) offered R1 her meal tray and R1 refused the tray. V24 and V22 stated R1's meal intake was variable and V22 offered her a nutritional supplement when she did not eat. After V22 was informed R1 enjoyed hotdogs, V22 offered a hot dog to R1 and R1 accepted the offer. V22 ordered the meal item from the kitchen and R1 ate 100% of the hot dog. Review of R1's clinical record, dated April 9-May 4, 2026, shows several reports that R1 experienced poor oral intake/appetite and diarrhea. The record shows R1 experienced persistent hyperkalemia and hyponatremia and had multiple physician orders for doses of lokelma to reduce elevated blood potassium levels between April 9, 2022 to May 10, 2026. The record showed R1's potassium on April 30, 2026 was elevated to 6.7 milliequivalents per liter. On May 4, 2026, R1 was readmitted to the hospital for low serum sodium and elevated blood potassium levels and R1 returned to the facility on May 10, 2026. Medical Professional note, dated April 23, 2026, shows, Resident evaluated for persistent hyperkalemia and hyponatremia. Recent labs show potassium previously elevated up to 6.8 milliequivalents per liter despite treatment with lokelma. Sodium remains low. Patient is currently on multiple medications contributing to electrolyte abnormalities including dual loop diuretics and potassium-elevating agencies. Likely multifactorial with significant contribution from medications (diuretics and possible SIADH). Hold furosemide, bumetanide, spironolactone, amiloride, losartan and sertraline x1day. Administer lokelma. POS (Physician Order Sheet) show R1 had physician orders for a Low Concentrated Sweets Diet until May 10, 2026 at the facility. The POS shows a physician order for R1 to be weighted upon Admission/readmission weekly for four weeks and then monthly. Facility Weights and Vitals Summary, printed May 14, 2026, shows R1's facility weights included 230.6 pounds (April 10, 2026), 191.4 pounds (May 1, 2026), and 214.2 pounds (May 12, 2026). R1's April 10, 2026 weight showed R1 lost 16.9% since April 10, 2026. R1's May 12, 2026 weight shows R1 lost 7.9% since April 10, 2026. The summary fails to show weekly weights were performed as ordered by the physician. On May 14, 2026 at 10:32 AM, V2 (Director of Nursing) stated (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there were no weekly weights as ordered by the physician documented in R1's clinical record. Review of meal intake, dated April 9, 2026 to May 14, 2026, shows R1 ate less than 75% of her meals 29 of 54 meals served at the facility. R1 refused her meal a total of 7 times. Review of R1's clinical record, dated 4/9/26 to 5/11/26, shows R1's only nutrition documentation was written by V21 a CDM (Certified Dietary Manager) on April 13, 2026. The assessment shows R1 was receiving a Low Concentrated Sweets Diet, it was unknown if R1 had previous weight loss, R1 was eating 26-75% of her meals, and R1 was identified as being malnourished. The note shows recommendations were made for double protein to provide extra calories and to restrict her diet to No Added Salt due to having a congestive heart failure diagnosis. Review of R1's clinical record showed no evidence that a dietitian performed a nutrition assessment of R1's clinical condition. On May 12, 2026 at 3:14 PM, V21 (Certified Dietary Manager) stated she normally emails the dietitian her recommendations for residents and the dietitian either carries out the recommendation or chooses a different approach. V21 stated she did not remember V23 calling her about R1 On May 13, 2026 at 1:56 PM, V23 (Dietitian) stated she visits the facility once a week and assesses new admitted residents unless V21 sees the resident. V23 stated sometimes she notes on residents seen by V21 and sometimes she does not. V23 states sometimes she visits residents but does not put a note in. V23 stated she spoke with R1 when R1 arrived at the facility, asked for R1's food preferences. V23 stated both she and V21 complete nutrition assessments. V21 refers any high risks to V23 and V23 completes the assessments. If V21 has any recommendations, she lets V23 know and V23 either carrys out the recommendation if she agrees with the recommendation or V23 will change the recommendation. V23 stated R1 should have been referred to V23 by V21 because she was high nutritional risk. V23 stated R1's critical lab values should have been referred to her so she can follow up and make changes as appropriate. V23 stated she spoke with R1 when she was having variable intake but declined supplements because she had diarrhea. V23 stated she declined V21's double portion recommendation because R1's intake was variable but did not recommend any further interventions. On May 13, 2026 at 1:38 PM, V1 (Administrator) stated new resident admissions should be seen first on admission by the dietary supervisor. V1 state V21 (CDM) and V23 (RD) share the workload of residents. V1 stated residents to go to the hospital and are readmitted to the facility should be seen by V21 or V23 as soon as possible on readmission. V1 stated the facility meets weekly to discuss residents at nutrition risk and discuss weights. V1 stated if anything nutrition wise is discussed, they communicate it to V23 and she meets with the residents the next time she visits. On 5/13/26 at 2:31 PM, V2 (Director of Nursing) stated the dietitian reviews all resident labs during initial assessment and when she visits every week. V2 stated if there were critical labs that needed review by the dietitian, the nurses would call V23. Facility Weight Policy, revised 7/3/25, shows, The significant weight changes (monthly 5%, quarterly 7.5% and every 6 months (10%) will be assessed and addressed by the IDT (Interdisciplinary Team) which includes but not limited to the dietitian, physician, medical specialist, speech therapist, nutritionist, and nurses. Nutrition Assessment Policy/Procedure, dated 2017, shows, The consultant dietitian provides in-depth nutrition assessments for clients whose nutrition conditions(s) may place them at nutrition risk. Nutrition assessment data may include body mass index, usual body weight, height, weight, diagnosis, diet, level of mobility, self-help required, vision, oral status, alertness, food preferences, nutrition-related lab values, skin condition, client's appearance and an estimation of needs. The healthcare community and the dietitian work together in determining level of nutritional risk. Medical conditions which may place clients at nutrition risk includes; Enteral or parenteral tube feeding, Pressure injury, Dialysis, Significant weight loss. The dietitian will provide random checks of the nutrition screens/ assessments completed by food and nutrition services personnel and this will be noted on the dietary consultant report. Facility Nutrition Assessment In-Depth Policy/Procedure, dated 2017, shows, The dietitian provides in-depth nutrition assessments for clients whose medical condition(s) may place them at nutrition risk. The healthcare community refers clients determined to be at nutritional risk to the dietitian. Medical conditions which may place clients at nutritional risk (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include but are not limited to the following: Enteral or parenteral tube feeding, pressure injury, dialysis, and significant weight loss. In-depth nutrition assessment may include the same data as ais included in nutrition assessment. An in-depth nutrition assessment also includes analysis of the data to identify nutrition-related problems and to determine, when possible, their causes. The dietitian exercises clinical judgment to determine the best nutrition approach(s) by recommending interventions appropriate to the individual. The dietitian may follow up on the clients who are at nutritional risk on a monthly or more frequent basis. Nutrition approaches are re-evaluated as needed to determine if they continue to be appropriate. Facility Nutritional Assessment document, undated, shows, Nutritional assessment is the process of gathering information from a multitude of sources and includes the organization and evaluation of the information to make a judgement regarding the individual's nutritional status that includes determination of nutritional needs, care planning with interventions, and monitoring a resident's response to the interventions and nutritional status Early screening and evaluation of nutritional status allows the health professional to identify early screening and evaluation of nutritional status allows the health professional to identify early deficiency states, to recognize those who are at increased nutritional risk, and to implement nutritional interventions in a timely manner Facility Interventions for Weight Loss Policy/Procedure, dated 2017, shows Interventions are provided to address a decline in a client's appetite and food intake, a significant weight loss or an insidious weight loss trend. Nutrition interventions can be initiated by a member of the healthcare team prior to assessment of the client's nutrition status by the dietitian. Certified Dietary Manager, Certified Food Protection Professional Scope of Practice, dated 2025, shows individuals with CDM certificates are qualified to gather and apply nutrition data such as gathering routine nutrition screening data, calculating nutrient intake and distinguishing between routine and at-risk residents. The document shows a CDM can identify nutrition issues and review/verify clinical documentation, and identify when further intervention is needed for referral to the RD.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop an effective analgesic regimen, reassess a residents unrelieved pain, develop a care plan for pain management or notify the physician of unrelieved pain in accordance with facility policy.This applies to 1 of 1 resident (R94) reviewed for pain management.The Findings include:R94's, EMR (Electronic Medical Record) showed R94 was[AGE] years old and admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease with dependence on hemodialysis, aftercare follow a right hip replacement, diabetes type 2 and Barrett's esophagus disease.R94's BIMs (Brief Interview for Mental Status) assessment dated [DATE], showed R94 was cognitively intact. On May 11, 2026, at 11:01 AM, R94 was sitting up in bed, using foam abduction pillow between both legs and stated she is uncomfortable when sitting up in a chair and especially uncomfortable while in dialysis. R94 explained that she recently had hip surgery.On May 14, 2026, at 9:05 AM, R94 was sitting up in the chair with her legs extended and elevated. R94 stated she had pain of 7 out of 10 and stated the medication was not helping and she wished someone would do something about it.On May 14, 2026, at 9:10 AM, V6 (RN) was informed of R94's reported pain of 7 out of 10. V6 stated R94 had just received Tramadol 25 mg (milligrams) at 8:17 AM, almost an hour earlier. V6 stated R94 is only on Tramadol 25 mg and that might not be enough for R94.R94's pain assessment completed on May 7, 2026, showed R94 had no pain. R94's pain score record showed R94's admission pain score documented was 3 on May 7, 2026, at 9:29 PM. R94's documented pain scores ranged between 0-7 from May 7, 2026, through May 14, 2026. R94's May MAR (Medication Administration Record) showed R94 had prescribed Tylenol 500 mg 2 tablets administered three times a day between morning and bedtime and had Tramadol 25 mg ordered as needed every 6 hours as needed prescribed for pain. As of May 14, 2026, 9:15 AM, Tramadol had only been administered 4 times since admission. There was an additional order for Tylenol to be given as needed, but no indication of when either Tylenol or Tramadol should be administered.R94's care plan for pain initiated on May 7, 2026, was not individualized, with blank spaces for medication name, type of pain, and reason for pain. The care plan did not include a pain score goal for R94.On May 14, 2026, at 1:04 PM, V2 (DON) stated if an initial pain score is documented as a 3, the initial pain assessment should reflect that initial pain score. V2 stated if a resident's pain is not relieved, the physician/healthcare provider should be contacted.The facility's policy titled Pain, dated July 29, 2025, showed it is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is potential for pain. The policy showed the residents will be assessed for pain upon admission and if the resident experiences unrelieved pain, despite pharmacological and nursing measures the resident's physician will be called and informed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and document review, the facility failed to follow their policy for proper controlled medication documentation, storage, and disposal.This applies to 2 of 4 residents (R40, R98) reviewed for controlled medication storage, labeling, and disposal in the sample of 23. Findings include:1. On May 13, 2026, at 2:38 PM, The facility's medication storage room was inspected in the presence of V20 (Nurse). V20 opened the medication storage refrigerator and there was a clear locked box that contained an unopened box of controlled medication (30 milliliters of morphine). V20 said she was new at the facility and was not aware there was any controlled medication stored in the refrigerator. The controlled medication box had a medication label that showed R98's name. V20 said she had worked two shifts on the unit, and they did not account for the controlled medication in the refrigerator at the beginning and end of shifts. V20 looked in the EMR (Electronic Medical Records) and said R98 was discharged from the facility on December 23, 2025. 2. On May 14, 2026, at 2:06 PM during medication cart inspection with V17 (Nurse), R40's controlled medication sheet did not match with the number of medications remaining in R40's medication bingo cart. R40's medication bingo card showed R40 had 18 tablets of controlled medication (hydrocodone-APAP 10-325 MG tablet) remaining. R40's controlled drug administration record sheet showed one tablet was signed out at 10:30 AM on May14, 2026 by V17. V17 said R40 had requested the medication at 10:30 AM and she did not administer the medication because the R40 went to therapy. R40's EMR medication administration record also showed the medication not administered. V17 said she was not supposed to document on the controlled drug administration record sheet if she did not pop the medication out of the medication bingo card.On May 14, 2026, at 2:45 PM, V2 (Director of Nursing/DON) said nurses must account for all controlled medications before and after each shift by counting the medications in the locked medication cart and the refrigerator. V2 said he was at fault for not disposing of the controlled medication for R98 after discharge from the facility a few months ago. V2 said R98's narcotic medication should have been disposed immediately after discharge. V2 said the facility's controlled medication recording practice was to document in the controlled drug administration record only when a medication had been removed from the medication bingo card. V2 also said the number and amount of the controlled medications must always match with the count recorded on the controlled drug administration record, and the medication administration record for each resident. V2 said, It's hard to tell if the staff are taking the medications or administering to the residents if the counts do not match. V2 also said there is potential for controlled medication diversion if medications are not disposed of and properly accounted for at the facility. The facility's policy titled, Medication Storage, Labeling, and Disposal with a revised date of July 2, 2025, showed, Policy Statement: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications. 6. Controlled meds should be disposed properly to prevent accidental exposure and diversion using Drug Buster or Rx Destroyer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145944	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Aurora	400 West Sullivan Road 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications as ordered. There were 26 medication opportunities with 2 errors resulting in a 7.69% medication error rate. This applies to 2 of 6 residents (R16, R29) observed for medication administration in the sample of 23. The findings include:1. On May 12, 2026, at 11:28 AM, V17 checked the medication order on the EMAR (electronic medication administration records), which stated, Difluprednate ophthalmic emulsion 0.05 percent, instill one drop in the right eye four times a day for post-cataract surgery. V17 removed an eye drop medication from the medication cart; the label on the bag matched the order exactly. V17 administered one drop of the eyedrops to R29's right eye; it got onto R16's eyelash, and V17 administered another drop to R29's right eye. V17 was inserting the eye drop bottle in the medication bag, and the eye drop bottle label V17 administered to R29 showed, brinzolamide suspension one percent ophthalmic. V17 said she only checked the label on the eye drops bag, did not check the eye drop bottle, and now noticed she administered the wrong eye drop to R29. V17 said the brinzolamide suspension one percent ophthalmic was the only eye drop bottle R29 had in the medication cart.2. According to the EMR (Electronic Medical Records), R29 had multiple diagnoses, including gastrostomy status, hypertensive heart disease without heart failure, and paraplegia unspecified.R29's Physician Order Summary showed active orders for hydralazine HCl Oral Tablet 25 MG (milligrams), give one tablet via G-Tube (Gastrostomy tube) every eight hours as needed for HTN [hypertension] for SBP [systolic blood pressure] > [greater than] 160 AND Give one tablet via G-Tube four times a day for HTN.On May 12, 2026, at 12:44 PM, V16 was preparing the 12:00 Noon G-tube medication for R29. R29's EMAR showed, Administer hydralazine HCl Oral Tablet 25 MG, give one tablet via G-Tube every eight hours as needed for HTN for SBP > [greater than] 160 AND Give one tablet via G-Tube four times a day for HTN. R29's EMAR showed administration times for the hydralazine as four times a day for HTN (12:00 AM, 6:00 AM, 12:00, and 6:00 PM), AND every eight hours as needed for HTN for systolic blood pressure > [greater than] 160. V16 read the EMAR for R29's and said she would not administer R29's 12:00 Noon hydralazine because R29's SBP blood pressure was less than 160, and the order said to administer is greater than 160. On May 12, 2026, at 2:54 PM, V19, (Nurse Practitioner) said the resident's order stated to administer hydralazine HCl Oral Tablet 25 MG, give one tablet via G-Tube every eight hours as needed for HTN for SBP > [greater than] 160 AND Give one tablet via G-Tube four times a day for HTN. NP said the order clearly stated what the nurses should do, including AND Give one tablet via G-Tube four times a day for HTN.On May 12, 2026, at 11:42 AM, V2 (Director of Nursing) said the nurses must check the medication orders to ensure they are administering the correct medications, dosages, and frequencies to the residents at the right times. V2 said the nurse must follow and administer the residents' medications according to the doctor's orders. He said the eye drop V17 administered to R29 was not on R29's medication order as of May 12, 2026, at 11:58 AM, and it was discontinued on April 10, 2026. V2 also said the nurses must check the labels on the eye drop bottles, in addition to checking the pharmacy labels on the medication labels, to ensure both match the doctor's orders correctly. V2 also said nurses must always administer the correct medications to residents to prevent adverse reactions, unwanted side effects, and potential negative effects on residents' treatment regimens.The facility's policy titled, Medication Pass with a revised date of July 2, 2025, showed, Policy Statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to follow their policy for proper medication storage and labeling.This applies to 2 of 4 residents (R29, R43) reviewed for medication storage and labeling in the sample of 23. Findings include:1. On May 14, 2026, at 1:40 PM during medication cart inspection with V2 (Director of Nursing/ DON), R43's controlled medication (hydrocodone-APAP 5-325 MG tablet) bingo card pocket three were popped open with the tablet exposed. V2 said medications should not be left exposed and should have been disposed of by two nurses for infection control and to prevent medication diversion.2. On May 12, 2026, at 11:28 AM, during medication administration, a wrong eye drop medication not ordered for R29 was stored in R29's eyedrop medication bag with the correct pharmacy label. V17 administered the wrong eye drop to R29. R29's eye drops medication label and medication order showed, Difluprednate Ophthalmic Emulsion 0.05 percent. V17 administered an eye drop medication, Brinzolamide Suspension one percent Ophthalmic into R29's right eye.On May 12, 2026, at 11:42 AM, V2 (DON) said the nurses must follow and administer the residents' medications according to the doctor's orders and store all medications in the correct storage containers to avoid medication errorsThe facility's policy titled, Medication Storage, Labeling, and Disposal with a revision date of July 2, 2025, states, Policy Statement: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to serve portions of pureed pork in amounts indicated on the planned/approved facility menus. This applies to 2 of 2 residents (R73 and R99) reviewed for pureed diets in the sample of 23. The findings include:Facility document, dated May 14, 2026, shows R73 and R99 had physician orders for pureed diets. On May 12, 2025 at 11:47 AM during lunch service, V26 (Cook) provided one #8 scoop (4 fluid ounces) of pureed pork on each plate when serving two pureed diet lunches. When questioned regarding the serving size, V25 (Food Service Director) examined the diet spread sheet and stated the serving size pureed pork planned on the menu was 2-#10 scoops (approximately 7 fluid ounces total). V25 stated the first two pureed plates did not have enough pureed pork and instructed V26 to provide the third pureed plate with 2-#8 scoops (8 fluid ounces) of pureed pork. After the third/final plate of pureed pork was served, V26 used the #8 scoop and retrieved approximately 6 fluid ounces of pureed pork from the pan on the steamtable. V26 stated she originally pureed a total of three portions of pureed pork to serve at lunch. Facility Daily Spreadsheet Week 4 Tuesday shows the puree diets were to be served two #10 scoops of pureed breaded pork cutlet. Facility Pureed Breaded Pork Cutlet recipe, printed February 13, 2026, shows one serving of pureed breaded pork cutlet was to be served using two #10 scoops. Facility Serving Portions Policy/Procedure, dated 2017, shows Food shall be served in portions indicated on the cycle menu and on the standardized recipes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow their policy for contact isolation precaution and infection prevention practices during medication administration.This applies to 2 of 7 residents (R83, R93) reviewed for infection control in the sample of 23. Findings include:1. R93's POS (Physician Order Summary) dated May 4, 2026, showed an active order for Strict Contact Isolation for (positive) C-Diff [Clostridioides difficile - a bacteria that causes life-threatening diarrhea] every shift. The same POS also showed an order for Vancomycin HCl Oral Capsule 125 MG (Milligram), give one capsule by mouth four times a day for C-Diff for 10 days, start date: May 4, 2026, and end date: May 14, 2026.On May 11, 2026, at 12:49 PM, R93 had a sign on the door that says, STOP. CONTACT PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before entry. Discard gloves before room exits. Put on a gown before room entry. Discard gown before room exit. V18 (Regional Guest Relations Director) took a meal tray into R93's room without wearing any gown and gloves. V18 came out of R93's room and performed hand hygiene using alcohol-based hand sanitizer. V18 said she did not need to wear any PPE before entering R93's room because she only wanted to deliver a meal tray, and she had already sanitized her hands after leaving R93's room.On May 13, 2026, at 2:54 PM, V2 (Director of Nursing/DON) said the staff must wear proper PPE (Personal Protective Equipment) as stated on the isolation signage posted on the resident's door, which includes a gown and gloves. V2 said staff delivering a meal tray must wear gowns and gloves before entering the room. V2 said R93 was on contact isolation precautions for C-Diff, and that performing hand hygiene with hand sanitizer alone after exiting the room is not appropriate. V2 said the staff must perform hand hygiene using soap and water after exiting the room.2. On May 12, 2026, at 10:21 AM, V17 (Nurse) was preparing medications for R83 while touching different surfaces on the medication cart with her bare hands. V17 popped R83's medication out of the bingo card, and it dropped on the medication cart. V17 picked up the medication with her bare hands without performing hand hygiene and administered it to R83.On May 12, 2026, at 11:42 AM, V2 (DON) said if the medication is dropped on the med cart, the nurses are not to administer it to the residents to prevent the spread of infection from potential contamination of the medication cart surface. The facility's policy titled, Infection Prevention and Control with a revised dated, June 30, 2025, showed Policy Statement: The facility has established a policy to identify, record, investigate, control, test, and prevent infections in the facility. Precautions to Prevent Transmission of Infections agents and Transmission Based Precaution: . 2. Contact Precaution - intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or environment. Examples of infectious organ isms requiring contact precaution are C. Difficile, .b. Use of Gown and glove is necessary prior to room entry.