

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145990	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER The Sapphire at Maple Crest		STREET ADDRESS, CITY, STATE, ZIP CODE 4452 Squaw Prairie Road Belvidere, IL 61008	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review the facility failed to ensure call lights were answered in a timely manner for 7 of 7 residents (R1-R7) who require assistance from staff reviewed for activities of daily living in the sample of 7. The findings include: On 7/16/26 at 1:06 PM, R1 stated staff take forever to change my incontinent brief. I wait up to three hours at night usually. Staff don't get me dressed and out of bed in time for my physical therapy some days. Sometimes I am still naked when therapy comes in to get me, then it gets pushed back to later in the day. V8 (family member) stated I visit often, and she is waiting for staff help many days when I arrive. They are fast on some shifts, but super slow on others. On 7/16/26 at 10:50 AM, R2 and R3 (roommates) said the call lights take a long time to be answered. R2 said second shift is the worst. It is up to 45 minutes to get someone in here. I have waited 3.5 hours with bowel movement in my pants in the past. R3 said I have to wait over an hour to be transferred back into bed. That is why I don't like to get up very often. Staff just do it whenever they want to do it. I hate it and have had UTIs from sitting in a wet brief so long. On 7/16/26 at 10:45 AM, R4 said sometimes it takes over an hour to get someone in here to answer my call light. The nights are the worst. The response time should be quicker. On 7/16/26 at 11:00 AM, R5 said call lights take so long to be answered that I don't even bother to use it. On 7/16/26 at 12:30 PM, R6 said I wait a long time for the call light to be answered. I guess it's because I am way down here at the end of the hall. On 7/16/26 at 12:55 PM, V9 and V10 (R7's family members) stated they visit R7 several times a week. They need more help around here. We are okay with R7's care because we come in a lot and that helps things. It is the other residents that look like they need more one-on-one care some days. On 7/16/26 at 1:49 PM, V2 (Director of Nurses) stated call lights should be answered as quickly as possible. The expectation is to be answered in 10 to 15 minutes. Waiting over an hour is not acceptable. Incontinent residents should be changed right away. There is the potential for skin breakdown, infection, and a lack of dignity. V2 confirmed R1-R7 all need staff assistance with toileting and incontinence cares. The facility's Supporting Activities of Daily Living (ADL) policy last review dated 12/4/25 states: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were administered as ordered for 1 of 3 residents (R1) reviewed for medication administration in the sample of 7. The findings include: R1's face sheet dated 7/16/26 showed diagnoses including but not limited to difficulty walking, diabetes mellitus, asthma, hypertension, hyperlipidemia, and bilateral osteoarthritis of knees. R1's facility assessment dated [DATE] showed no cognitive impairment and no memory problems. R1's July 2026 physician order summary report showed orders for metformin to be given every morning and bedtime for diabetes mellitus. The report showed montelukast to be given at bedtime for asthma. The report showed acetaminophen (Tylenol) to be given every eight hours as needed for pain. The report showed hydrocodone-acetaminophen (Norco) to be given every six hours as needed for pain. On 7/16/26 at 1:06 PM, R1 stated she had a problem with her medication administration last week. R1 said it was all documented on her cell phone. R1 opened her phone and reviewed her notes. R1 said it was on July 9, and the nurse gave the wrong medicine. R1 said she had to wait over an hour for pain medication. R1 said she asked for Tylenol at 4 PM and did not get anything until after 5:30 PM. R1 stated when the nurse finally came in with the Tylenol, there were other tablets in the cup too. R1 clarified that the pills were the ones prescribed to her, but the nurse was trying to give them too soon. R1 said she knew the extra pills were her montelukast, metformin, and Norco which she does not take until bedtime. R1 said she refused to take anything but the Tylenol. R1 said she had to tell the nurse what to do. R1 said she was also concerned with her medications because for the last two days she has missed getting the montelukast. R1 said she did not know why the nurses had not been getting it to her as ordered. R1's July 2026 MAR (Medication Administration Report) was reviewed for 7/9/26. The report showed montelukast scheduled to be given at bedtime and metformin scheduled for 8 AM and 8 PM. The same report showed both were administered at 8 PM and with the 8 PM Norco. There was no documentation of the Tylenol ever having been given in the afternoon on 7/9. Progress notes showed Norco declined by R1 on 7/9 at 5:41 PM. R1's July 2026 MAR showed the montelukast documented with a number 9 for 7/14 and 7/15. The number 9 corresponded to Other/see progress notes. The progress notes for both dates showed the medication was on order. On 7/16/26 at 1:49 PM, V2 (Director of Nurses) stated any resident reporting pain should be addressed immediately to ensure comfort and reduce pain. Ongoing pain can start other health issues. Addressing pain sooner keeps it easier to control. R1 should have received the Tylenol within 15 minutes. The nurse should have responded quicker or tried something else until the medication was administered. V2 said scheduled medications can be given one hour before and one hour after. It is considered an error if it is given outside that parameter. If the time in between is too close or too far apart, it can affect the therapeutic levels. Missing medication can affect resident health. It is important nurses give medication as ordered and at the scheduled times. The facility's Medication Administration policy last review dated 4/5/26 states: All medications are administered safely and appropriately to aid resident to overcome illness, relieve and prevent symptoms and help in diagnosis.		