STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146193	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Rochelle	2203 Flagg Road Rochelle, IL 61068

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 22499 Based on interview and record review the facility failed to complete resident comprehensive assessments in a timely manner. This applies to 4 of 4 residents (R1, R21, R26 and R177) reviewed for comprehensive assessments in the sample of 18. The finding include: On 3/4/25 R1's Minimum Data Set (MDS) Assessment Tracking shows that R1's Comprehensive Assessment was due to be completed on 1/25/25. It is listed as In Process. On 3/4/25 R21's Minimum Data Set Assessment Tracking shows that R21's Comprehensive Assessment was due to be completed on 12/11/24. It is listed as In Process. On 3/4/25 R26's Minimum Data Set Assessment Tracking shows that R26's Comprehensive Assessment was due to be completed on 12/11/24. It is listed as In Process. On 3/4/25 R177's Minimum Data Set Assessment Tracking shows that R125's first Admission Comprehensive Assessment was due to be completed on 1/18/25. It is listed as In Process. On 3/44/25 at 12:31 PM V2 (Interim Director of Nursing (DON)/MDS Coordinator) stated, Last week I think I sent out 2 emails that had 10+ people that showed that my part was completed. They were behind. I passed them off to the people that need to finish their parts. When I first started, we were about 3 months behind so that took some time to get caught up. At 1:30 PM V2 stated, When we lost our DON in September, I took over as interim DON but and I can't do both that and keep up with the MDSs.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition 22499 Based on interview and record review the facility failed to complete resident significant change assessments in a timely manner. This applies to 4 of 4 residents (R24, R25, R48 and R49) reviewed for significant change assessments in the sample of 18. The finding include: On 3/4/25 R24's Minimum Data Set (MDS) Assessment Tracking shows that R24's Significant Change Assessment was due to be completed on 1/30/25. It is listed as In Process. On 3/4/25 R25's Minimum Data Set Assessment Tracking shows that R25's Significant Change Assessment was due to be completed on 1/29/25. It is listed as In Process. On 3/4/25 R48's Minimum Data Set Assessment Tracking shows that R48's Significant Change Assessment was due to be completed on 1/22/25 . It is listed as In Process. On 3/4/25 R49's Minimum Data Set Assessment Tracking shows that R49's Significant Change Assessment was due to be completed on 2/20/25. It is listed as In Process. On 3/44/25 at 12:31 PM V2 (Interim Director of Nursing (DON)/MDS Coordinator) stated, Last week I think I sent out 2 emails that had 10+ people that showed that my part was completed. They were behind. I passed them off to the people that need to finish their parts. When I first started, we were about 3 months behind so that took some time to get caught up. At 1:30 PM V2 stated, When we lost our DON in September, I took over as interim DON but and I can't do both that and keep up with the MDSs.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 22499 Based on interview and record review the facility failed to complete resident quarterly assessments in a timely manner. This applies to 4 of 4 residents (R17, R50, R58 and R224) reviewed for quarterly assessments in the sample of 18. The finding include: On 3/4/25 R17's Minimum Data Set (MDS) Assessment Tracking shows that R17's Quarterly Assessment was due to be completed on 1/1/25. It is listed as In Process. On 3/4/25 R50's Minimum Data Set Assessment Tracking shows that R50's Quarterly Assessment was due to be completed on 1/8/25. It is listed as In Process. On 3/4/25 R58's Minimum Data Set Assessment Tracking shows that R58's Comprehensive Assessment was due to be completed on 1/15/25. It is listed as In Process. On 3/4/25 R224's Minimum Data Set Assessment Tracking shows that R224's Quarterly Comprehensive Assessment was due to be completed on 1/15/25. It is listed as In Process. On 3/44/25 at 12:31 PM V2 (Interim Director of Nursing (DON)/MDS Coordinator) stated, Last week I think I sent out 2 emails that had 10+ people that showed that my part was completed. They were behind. I passed them off to the people that need to finish their parts. When I first started, we were about 3 months behind so that took some time to get caught up. At 1:30 PM V2 stated, When we lost our DON in September, I took over as interim DON but and I can't do both that and keep up with the MDSs.

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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** 35541 Based on observation, interview and record review the facility failed to provide incontinence care/toileting to a resident that required staff assistance for toileting for 1 of 18 residents (R65) reviewed for activities of daily living (ADLs) in the sample of 18. The findings include: R65's resident assessment dated [DATE] showed R65 required maximum staff assistance for toileting and transfers. R65 had a history of incontinence. The assessment showed R65 was cognitively impaired. On 3/3/25 at 9:17 AM, R65 was seated in a wheelchair in his room. A strong smell of urine was noted in R65's room. At 9:19 AM, V8 and V9 Certified Nursing Assistants (CNA) transferred R65 from his wheelchair to the toilet. The inner left groin and left buttock areas of R65's sweatpants appeared wet with urine. V9 CNA removed R65's brief and stated, Wow, that's (R65's brief) heavy. R65's brief was saturated with urine and a moderate amount of soft stool. R65's buttocks appeared red. V9 CNA looked at R65's pants and stated, These are wet. We need to change his pants. V8 CNA stated, This is my first time changing or toileting (R65) today. I am not sure when he was last changed. It would have been sometime on nights. He was up and dressed when I got here this morning. On 3/4/25 at 10:49 AM, V2 Director of Nursing (DON) stated staff are to toilet and/or provide incontinence care to residents every two hours.

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NAME OF PROVIDER OR SUPPLIER: Manor Court of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE: 2203 Flagg Road Rochelle, IL 61068	

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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. 45540 Based on observation, interview, and record review the facility failed to ensure the narcotic reconciliation count was accurate. This applies to 1 of 1 (R274) in the sample of 18 reviewed for narcotics. The findings include: On 3/4/2025 at 8:15AM, the narcotic count was checked for the medication cart with V10 Licensed Practical Nurse (LPN). V10 pulled up R274's narcotic count sheet on their computerized charting. R274s' Tramadol 50mg card was selected. R274 had two Tramadol 50mg cards, one with 30 tablets and the second one had 19 tablets for a total of 49. V10 said the count was off this morning because a nurse forgot to sign out a medication. V10 said [R274] has scheduled Tramadol 50mg three times per day. V10 said she notified [V2 Director of Nursing] this regarding the count being off. On 3/4/2025 at 12:24AM, V2 Director of Nursing (DON) said she was made aware the count was off. V2 said she did investigate why the count was off. V2 said [V10] didn't sign out the Tramadol dose that was given during the 7:00AM - 10:00AM on 3/3/2025, which caused the count to be off. V2 said there was no misappropriation, the nurse just didn't sign out the dose. R274's 14 Day Administration History dated 3/4/2025 shows R274 received all doses of Tramadol 50mg from 2/19/2025 - 3/3/2025, and the AM dose on 3/4/2025. The facility provided Pharmaceutical Procedures revised 1/5/2023 states, . Controlled Substances . individual resident control sheets shall be utilized for all controlled substances. The record shall list for each prescription the following information: . number of doses remaining. a shift count will be done every shift by the off-going and on-coming nurses to verify doses remaining. A shift count form or electronic record will be used for this purpose and signed by both nurses.

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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. 45540 Based on observation, interview and record review the facility failed to label an insulin pen with an opened date. This applies to 1 of 1 (R49) in the sample of 18 reviewed for insulin. The findings include: On 3/4/2025 at 8:00AM, R49's Humalog insulin pen was in the medication cart with no opened date, while checking the medication cart on the unit. V10 Licensed Practical Nurse (LPN) said the insulin pen should be dated when opened. On 3/4/2025 at 12:24PM, V2 Director of Nursing (DON) said insulin pens should be dated when opened. R49's Physician Order Report dated 2/3/2025 - 3/3/2025 shows an order for Humalog KwikPen Insulin (insulin lispro) started on 9/22/2025. The facility provided Insulin Administration Procedure revised 02/04 states, . Date insulin vials when opened. Loss of potency may occur when the bottle has been in use >30 days.

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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. 34314 Based on observation, interview and record review the facility failed to ensure puree diet textures were smooth. This applies to 3 of 3 residents (R9, R176, R51) for puree diets in the sample of 18. The findings include: The facility's lunch menu for March 3, 2025 shows, Swiss steak with gravy, mashed potatoes and gravy, whole kernel corn, peanut frosted chocolate cake, beverage. The spreadsheet for the lunch meal shows, the same meal except creamed corn instead of whole kernel corn for pureed diets. On March 3, 2025 at 11:10 AM, V4 cook pureed Swiss steak for the noon meal. He pureed it until he thought it was pureed enough. He stated, It's gritty and I don't know how to get rid of the grittiness and plated the Swiss steak. The Swiss steak had small chunks of meat in it and the texture was not smooth. After the Swiss steak was pureed, V5 cook pureed the creamed corn for the noon meal. She pureed it some and stated, it's hard to puree and plated it. The creamed corn had hulls in it and was not smooth. On March 3, 2025 at 1:20 PM, V3 Dietary Manager stated, the puree at the noon meal was gritty and should be smooth. She also identified 3 residents (R9, R176 & R51) receiving pureed diets. The facility's pureed volume method procedure dated July 2020 shows, Objective: To provide guidelines to puree food to appropriate texture for meals. Description: The Pureed Diet is a mechanically altered diet. The diet is designed to permit easy chewing and swallowing. The Regular Diet is modified in consistency and texture by pureeing foods to a smooth mashed potato consistency with no lumps or particles visible .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to implement and follow Enhanced Barrier Precautions (EBP) for 3 of 18 residents (R19, R12, R8) reviewed for infection control in the sample of 18. The findings include: 1. R19's care plan dated 1/7/25 showed R19 is on enhanced barrier precautions due to her wounds on her left calf and mid back . Staff will be provided with appropriate PPE (personal protective equipment) to provide (R19's) care . R19's wound care note dated 2/28/25 showed R19 had a cancerous wound to her right lower back area measuring 2.3 cm (centimeters) x 2.2 cm x 0.2 cm. On 3/3/25 at 9:10 AM, an EBP sign hung on the door to R19's room. R19 was seated on the side of her bed. A large, square gauze dressing was noted to R19's right lower back area. On 3/3/25 at 9:35 AM, V7 Registered Nurse (RN) donned gloves, but no protective gown. V7 then entered R19's room. As R19 laid on her bed, V7 RN removed the dressing from the wound on R19's back. V7 RN provided wound care and applied a new dressing to R19's back wound. 2. R12's Resident Face Sheet dated 12/16/22 showed R12 had a diagnosis of ESBL (Extended Spectrum beta lactamase infection) of his urine. R12's resident assessment dated [DATE] showed R12 was always incontinent of urine. R12 required assistance with toileting/incontinence care. On 3/3/25 at 9:50 AM, R12 was seated in his room. No EBP sign was noted on or around the door to his room. No cart containing PPE equipment was noted outside of R12's room. On 3/4/25 at 8:10 AM, V6 Infection Preventionist was observed placing an EBP sign on the door of R12's room and placing an isolation cart full of PPE outside of his room. On 3/4/25 at 10:41 AM, V6 Infection Preventionist stated, I was notified yesterday that (R12) has a history of ESBL of his urine. I was not aware of that previously. I put him on EBP precautions this morning. He does also have a history of urinary incontinence. V6 stated EBP precautions are required for all patients that have urinary catheters, intravenous access, feeding tubes, wounds, and a history of colonized ESBL. V6 stated any nursing staff providing wound care must wear a gown and a protective gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enhanced Barrier Precautions policy dated 8/8/22 showed, It is the policy of the facility to use proper PPE (Personal Protective Equipment) during high-contact resident care opportunities for transfer of MDROs (Multi-drug resistant organisms) to staff hands and clothing . Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated, when Contact Precautions do not otherwise apply, for residents with the following: a. Wounds or indwelling medical devices . b. Colonization with an MDRO . Examples of MDROs include . ESBL-producing Enterobacteriaceae . Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions may include: Dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use . wound care . 45540 3. On 3/3/2025 at 9:00AM, an enhanced barrier precautions (EBP) sign was observed on the door frame of R8's room. V11 Student Nurse was observed coming out of R8's bathroom while pushing R8 in a wheelchair, without gown and gloves on. V11 said she was helping R8 in the bathroom. V11 said she was unsure why [R8] was on isolation precautions. On 3/3/2025 at 9:09AM V10 Licensed Practical Nurse (LPN) said staff working with residents on EBP should have a gown and gloves on. V10 said gown and gloves are worn to prevent the spread of infection. V10 said [R8] is on EBP for wounds. On 3/4/2025 at 1:26PM, V2 Director of Nursing (DON) said if a resident is on EBP and staff are helping the resident, in direct physical contact with the resident staff should wear gown and gloves. R8's Physician Orders dated 2/3/2025 - 3/3/2025 shows an order for Enhanced Barrier Precautions with a start date 1/1/2025. The facility provided Enhance Barrier Precautions (EBP) policy adopted 8/8/2022 states, . EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities . EBP may be indicated . for residents with any of the following . wounds or indwelling medical devices.