STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146195	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical McHenry	550 Ridgeview Drive McHenry, IL 60050

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 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 to a resident (R1) per physician's orders. This applies to 1 of 4 residents reviewed for pharmacy services in the sample of 4.The findings include:R1's electronic face sheet printed on 12/11/25 showed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to interstitial pulmonary disease, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, congestive heart failure, and pulmonary hypertension. R1's physicians orders dated 11/27/25 showed,Incruse Ellipta Inhalation 62.5mcg/act 1 puff inhale 1 time a day for COPD.R1's medication administration record for November and December 2025 showed R1 did not receive his Incruse Ellipta inhaler from 11/28-12/1. (4 missed doses)On 12/11/25 at 10:18AM, V3 (R1's significant other) stated, The day after (R1) was admitted , I called the nurse & asked if he got his medications and the nurse said they were trying to find them, so he didn't have them yet. She said she couldn't get the inhaler and the Incruse because they needed some type of authorization because of the cost. She said she would go try to find them. The next morning (12/29) they didn't have the inhaler and the Incruse and the Combivent. Tuesday (12/2) I said I don't ever remember him getting his Incruse and the nurse said it wasn't on her schedule to give to him. She opened the medication drawer and his Incruse was there, and it had a date of 11/28 with his name and the directions. The medication was brand new and had never been opened. The day (R1) went to the hospital; I asked to see his medications and his Incruse had only 2 doses used for the 6 days (R1) was at the facility.On 12/11/25 at 12:12PM, V8 (Registered Nurse) stated, Pharmacy deliveries are twice a day but I'm not sure about the weekends. For new admissions we put all of their orders in the computer and the pharmacy usually gets the medications to us by the next day at the latest. We aren't usually informed by the pharmacy if a medication needs a prior authorization unless the pharmacy just doesn't deliver it. That's about the only way we know until they send a prior authorization slip to us. On 12/11/25 at 12:52PM, V11 (Licensed Practical Nurse) stated, I remember (R1's) wife asking for all of his medications when he went to the hospital and one of his inhalers, I think Incruse or something like that only had 2 doses used for the 6 days he was in the facility. She was pretty upset about that.On 12/11/25 at 2:10PM, V2 (Director of Nursing) stated, Medications arrive three times a day in the facility and we have STAT orders we can do too. We find out if medications need prior authorization before the residents are admitted so we can get that taken care of prior to admission. I wasn't aware (R1) needed any prior authorization for any medications. I'm not aware that he missed any doses of his Incruse. Nurses should be communicating with me when a medication is not available.The facility's policy titled, Physician's Orders dated 11/2024 showed, All medications will be administered as ordered by a healthcare professional .

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146195	A. Building B. Wing	12/12/2025

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Ignite Medical McHenry	550 Ridgeview Drive McHenry, IL 60050

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (R4) did not experience a significant medication error. This applies to 1 of 4 residents reviewed for medications in the sample of 4.The findings includeR4's electronic face sheet printed on 12/11/25 showed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to type 2 diabetes, cerebral infarction, dementia without behaviors, and atrial fibrillation.R4's physician's orders dated 12/3/25 showed, Insulin Glulisine 100units/ml Inject per sliding scale three times a day for diabetes mellitus .R4's medication administration record for December 2025 showed R4 did not receive any of his Insulin Glulisine doses on 12/4/25 (3 missed doses) and had blood sugar readings between 240-365 which would have required sliding scale insulin administration per R4's physician's orders.On 12/11/25 at 12:17PM, V9 (Licensed Practical Nurse) stated, Medications for new admissions come the next morning, we have a morning, afternoon, and nighttime run. If they have nighttime medications, they probably just wouldn't get the medications. I would notify the residents provider and pharmacy if insulin wasn't available upon admission. I was told (R4) couldn't be on 2 rapid acting insulins per his insurance, so he was changed to just 1. We should be calling the provider immediately if something significant like insulin isn't available, you can't just not give it. On 12/11/25 at 2:10PM, V2 (Director of Nursing) stated, Medications arrive three times a day in the facility and we have STAT orders we can do too. We find out if medications need prior authorization before the residents are admitted so we can get that taken care of prior to admission. I wasn't aware (R4) needed any prior authorization for any medications . (R4) missing his insulin doses is considered a significant medication error and should have been communicated to the physician immediately to obtain new insulin orders. Nurses should be communicating with me when a medication is not available.The facility's policy titled, Physician's Orders dated 11/2024 showed, All medications will be administered as ordered by a healthcare professional .The facility's policy titled, Administration of Medications dated 07/2025 showed, .22. If a medication is ordered but not available, check to see if it was misplaced and then call the pharmacy to obtain the medication.