STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A383	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks	2750 West Highland Avenue Elgin, IL 60123

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to develop and implement a comprehensive water management program plan to detect and control legionella and water borne pathogens in the facility's water system. This failure had the potential to affect all 20 residents in the certified section. The findings include: The resident roster provided by the facility on December 8, 2025, during the survey entrance conference shows 20 residents in the certified section. 1.On December 9, 2025, at 3:10 PM, V2 (Director of Nursing) and V10 (Maintenance Director presented the facility's Water Management Program, a 3 page document. While reviewing the facility's water system diagram together, V10 pointed to the drinking fountain on the drawing and stated the facility does not even have a drinking fountain, yet it was included in the water management plan as a part of the water system description. Review of the water system description did not include if there were any areas of deadlines, areas of corrosion in the pipes, or any areas of stagnant water. On December 11, 2025, 10:35 AM, V2 provided an additional policy that V2 stated was part of the facility water management program plan. The document, undated, titled Infectious Disease-Legionella showed Operation and Maintenance.storing of water is recommended above 140 degrees F (Fahrenheit) to continuously kill the Legionella bacteria. The facility provided documentation for monitoring water temperatures for 2024, and 2025, that showed the temperatures of the water heaters both number 1 and number 2 did not ever exceed 140F. On December 9, 2025, at 3:35 PM, V10 stated he had worked in the facility for 10 years and they have never done any water testing, either of the municipal water supply or within the facility for pH level, presence of chlorine or other disinfectant, or presence of bacteria including legionella to validate the effectiveness of the facilities control measures. The facility's water management plan for control measures identified the drinking fountain, ice machines, kitchen appliances, and sinks, tubs, and showers as areas within the facility with potential for bacterial growth. The CDC (Center for Disease Control) Developing a Water Management program to reduce Legionella Growth and Spread in Buildings dated September 30, 2025, showed Because of the vulnerable population served, inpatient healthcare facilities should conduct routine testing for Legionella to validate their WMP. (Water Management Program). The Water Management Plan provided by V2 and V10, (3 page document) did not address the method to be used to validate the effectiveness of their water management program and did not address water testing. On December 9, 2025, during the infection control interview regarding the facility's surveillance (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	activities, V2 (DON) identified an increase in the infection control rate to 6.18 % for the month of November 2025. V2 stated the increase was due to an increase in the number of residents who experienced pneumonia and respiratory infections in the month of November. V2 stated none of the residents were tested or sputum cultured to identify if there was a common organism present among the residents who became ill. The CDC (Center for Disease Control) Developing a Water Management program to reduce Legionella Growth and Spread in Buildings dated September 30, 2025, showed A healthcare facility's water management program to limit Legionella growth and spread should include the actions to take when a patient is diagnosed with Legionnaires' disease. include an investigation for Legionella in high risk residents who develop respiratory symptoms and have been in the facility for 10 consecutive days prior to the onset of symptoms. The Facility's Water Management Program did not include actions to take when a resident is diagnosed with Legionella disease or when high risk residents who have been in the facility for longer than 10 days develop symptoms of pneumonia and upper respiratory disease. The water management plan lacked an accurate description of the facility's water system, lacked effective monitoring methods for areas identified at risk for bacteria growth, lacked strategy for monitoring any water quality measures. The water management plan also failed to identify a plan for intervention in response to external risk factors, such a disruption in the facility's building water supply, changes in the municipal water supply, or construction, and failed to address internal risk factors such as biofilm, scale and sediment, water pressure changes and pH level and inadequate disinfection in accordance with CDC (Center for Disease Control) Developing a Water Management program to reduce Legionella Growth and Spread in Buildings dated September 30, 2025.

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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. Based on observation, interview and record review the facility failed to properly evaluate and treat a resident who sustained a burn injury from coffee spill.This applies to 1 of 1 resident (R20) reviewed for quality of care in the sample of 12.The findings include:R20's Nursing Progress Note documented by V13 (Nurse) on December 6, 2025, at 10:30 PM, showed a notification time to the physician of 8:30 PM. The note showed that R20 sustained a burn on his thigh while drinking coffee at dinner due to R20's tremors. Additionally, the note also showed that V21 (Physician/Medical Director) gave an order to apply moisturizer, watch for open area, cover with gauze dressing if tender, and to notify the provider if it worsens.R20's Nursing Progress Note showed an edited note documented by V13 on December 6, 2025, at 10:33 PM that when assessing R20's left thigh at bedtime, R20's left thigh was noted with redness, warm to touch, and with areas of blister fluid-filled sacs. The same Progress Note also showed that R20's POA and Physician were notified.On December 10, 2025, at 2:45 PM, V13 (Nurse) said she applied regular facility house supplied lotion to R20's thigh on December 6, 2025, and she passed the information on in shift-to-shift report but did not create a treatment order flowsheet for nurses to document.On December 10, 2025, at 2:40 PM, V8 (Nurse) said he was R20's nurse on December 7, 2025, December 9, 2025, and December 10, 2025. V8 said he was made aware of the burn from a hot coffee spill on R20's left thigh. V8 also added that he was told to apply lotion to R20's thigh. V8 said he applied the regular facility house supply lotion to R20's thigh. V8 also said there was no treatment order to follow, just instructions from the nurses' shift to shift report, and there was no treatment order to document monitoring the skin condition or when to apply lotion. V8 also added that R20 had Parkinson's disease, feeds himself with regular utensils, and has always had hand tremors.Review of R20's Treatment Administration Record for December 2025 showed there was no Treatment Order and no documentation of R20's left thigh burn wound.On December 10, 2025, at 4:10 PM, V21 said the facility notified her on December 6, 2025, regarding R20 spilling coffee on his left thigh at dinner time. V21 said R20 sustained a mild second-degree burn based on the photo of R20's burn the facility sent to her. V21 added that the expected protocol for the facility is that hot coffee cups should be covered with lids. In addition, V21 said R20 had some tremors in his hands due to diagnosis of Parkinson's Disease and would have benefited from assistive devices to help with his tremors. V21 said she gave an order to apply moisturizer, monitor for open areas, drainage and cover the area with a dressing gauze. V21 also said the facility did not notify her of the change in R20's wound being reddened, painful to touch, warm, with blistered fluid filled sacs at bedtime on December 6, 2025. V21 said she attempted to see R20's burn on December 7, 2025, but did not evaluate R20's wound because he was asleep.The facility's undated Skin Care Policy showed Policy . Prevention of skin problems requires consistent, ongoing monitoring, as well as standardized management to reduce risks of skin breakdown.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the physician and failed to implement pressure ulcer interventions to prevent the development of facility acquired pressure ulcers for a resident at high risk for developing a pressure ulcer.This applies to 1 of 3 resident (R20) reviewed for pressure ulcers in the sample of 12.The findings include:R20's face sheet showed that R20 was admitted to the facility on [DATE]. R20 had multiple diagnoses, including Parkinson's Disease with dyskinesia and dementia. R20's Quarterly (MDS) Minimum Data Set, dated [DATE], showed R20 had severe cognitive impairment. The same MDS also showed that R20 was dependent on the facility staff for toileting, showering, required moderate assistance for personal hygiene, and touch assistance for bed mobility. R20's Pressure Ulcer Care Plan dated April 30, 2025, showed that R20 was at high risk for skin failure related to advanced age, limited mobility due to Parkinson's disease, incontinent episodes, history of pressure wounds to buttocks, and spending most of the daytime hours sitting in a recliner, watching TV. Interventions for the same Care Plan showed that nurses are to conduct skin inspection weekly and document in the Observation Flowsheet. The intervention also included that the CNA (Certified Nursing Assistants) should notify nurses of any sign of skin breakdown, redness, blisters, bruises, and discoloration noted during daily cares.R20's Nursing Progress Notes for November 1, 2025, to December 10, 2025, the Weekly Wound Flowsheets dated November 11, 2025, November 17, 2025, November 24, 2025, and December 9, 2025, were reviewed. R20's Nursing Progress Note documented by V12 (Nurse) dated November 11, 2025, and the Weekly Wound Flowsheet documented by V22 on November 11, 2025, both showed that R20's right buttock wound was an open wound measuring 0.5 cm x 0.5 cm and was identified by the facility on November 11, 2025. On November 10, 2025, at 1:53 PM, V2 (Director of Nursing) said the facility must have missed the Weekly Wound Flowsheet documentation for the week after November 24, 2025, and there was no documentation to be provided.R20's Weekly Wound Flowsheet dated December 9, 2025, showed that R20's pressure ulcer has deteriorated, and an additional pressure ulcer had been identified on R20's right lower buttock.On December 10, 2025, at 11:44 AM, V17, CNA was assisting R20 in the bathroom with toileting. A foam dressing dated December 9, 2025, was on R20's right buttocks, there was no dressing noted on the left buttock.On December 10, 2025, at 12:50 PM, V17 (MDS coordinator/Nurse) was assisting R20 in the bathroom for incontinence care. V17 removed the foam dressing on R20's right buttock and R20 had an area of red open pressure ulcer on the right upper buttock measuring 0.5 cm x 0.5 cm which was covered with a Vaseline gauze dressing. R20's right lower buttock had a pink intact skin area covered with a Vaseline gauze. R20's left buttock had an area of red pressure ulcer measuring 0.3 cm x 0.3 cm, which was not documented in R20's EMR (Electronic Medical Records). According to a review of R20's Physician Progress Note and the Nursing Progress Note documentation, there was no documentation that V21 (Physician/Medical Director) was notified of R20's buttock wound.On December 10, 2025, at 4:10 PM, V21 said she was not notified about R20 developing pressure ulcers on his buttocks until today and her expectation is that the facility should notify her of residents' change in condition such as the development of a pressure ulcer. V21 said she would have provided the facility the appropriate treatment and additional pressure relieve orders to help heal and prevent further deterioration of R20's buttocks pressure ulcer if she had been notified as soon as the facility identified R20's wound. R20's Nursing Progress Note documented by V22 (Nurse) on December 10, 2025, at 12:10 PM showed the facility notified V21 of R20's right buttock wound and obtained a treatment order. There was no mention of notifying V21 of R20's newly developed reddened area pressure injury on R20's left buttock in the note.The facility's undated Pressure Ulcer Policy showed Policy: The facility will ensure that a resident that enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition indicates that they were unavoidable. Procedure: . 2. At least weekly, an evaluation of the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer will be documented. 3. MD [Medical Director] and POA [Power of Attorney] will be notified.

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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. Based on observations, interview and record review, the facility failed to provide mechanical soft consistency diet per menu spreadsheet and facility policy guidance. This applies to 1 of 1 resident (R10) reviewed for dining in the sample of 13. The findings include:R10's face sheet included diagnoses of cerebral infarction due to embolism of right middle cerebral artery, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, dysarthria following cerebral infarctionR10's diet order on POS (Physician Order Summary) included Mechanical Soft diet and Nectar Thick Liquid. R10's nutrition care plan (dated May 15, 2025) included that R10 is at risk for aspiration due to difficulty swallowing post stroke. Interventions for the same included (to serve) diet per Medical Doctor's order.1.Facility Fall/Winter menu for Monday, spreadsheet for December 08, 2025, included Sweet and Sour Pork Saute, [NAME] Rice, Sugar Snap Peas, Tropical Fruit.Menu spreadsheet for the lunch meal for December 08, 2025, included Tropical Fruit as the dessert. The same spreadsheet showed that residents on mechanical soft to receive 4 ounces of Tropical fruit salad with no pineapple and #16 scoop [2 ounces] of sugar snap peas. On December 08, 2025, at 12:33 PM, during the lunch meal service, V7 (Dietary Aide) was passing out desserts from a cart to the residents that were having their lunch. The desserts offered included Tropical fruit salad with pineapple, ice cream or cookie. When asked, V7 stated that residents on Regular and Mechanical soft diets can have Tropical fruit with the pineapple. R10 received Tropical fruit salad with pineapple and also sugar snap peas that were around 2 inches long, some of them with a hard stalk. R10 did not eat either the Tropical fruit salad with pineapple nor the sugar snap peas and stated that she is unable to chew them. On December 08, 2025, at 12:34 PM, V5 (Director of Dietary) stated that he did not see the Tropical fruit had pineapple in it. On relaying that the sugar snap peas had stalks on it, V5 stated that he will reach out to the dietitian as she usually changes the menu as needed. 2. On December 08, 2025, at around 10:00 AM, V5 stated that the facility is serving the residents choice for the meal of the month which included baked potato with toppings. V5 stated that he does not have a spreadsheet for the meal of the month but will follow scoop sizes and foods allowed based on the spreadsheet for these items served on other days.On December 08, 2025, at 12:22 PM, during lunch meal observations, R10 received baked potato with skin. R10 was noted to have occasional coughing and throat clearing while eating her meal. On December 08, 2025, at 12:32 PM, on enquiry whether residents on mechanical soft diet can have baked potato with skin, V5 stated that the facility's menu had shown baked potato for dinner on the same day. On review of the menu (week 5 day 3) for the dinner meal showed that residents on mechanical soft diet should be served baked potato without skin and V5 acknowledged the same. On December 08, 2025, at 2:13 PM, V9 (Dietitian) stated that the facility has a liberalized mechanical soft diet, and the speech therapist determines if the resident can tolerate foods/textures. V9 stated that the facility should follow the spreadsheet to serve diet consistencies as shown. V9 stated that if the vegetable is stringy and had a stalk it should not be served to residents on mechanical soft diets. Facility (undated) policy titled National Dysphagia Level 2: Mechanically altered Nutrition Therapy included that fresh, canned, or cooked pineapple to be avoided, and that vegetables allowed should be well cooked, less than 1/2 inch and should be easily mashed with a fork. Vegetables to be avoided included fibrous, non-tender, or rubbery cooked vegetables. Potatoes and starches to be avoided included potato skins and chips.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview and record review the facility failed to maintain food safe temperatures at the steam table. This applies to 3 of 3 residents (R15, R19, R24) reviewed for pureed diets in the sample of 14. The findings include: Facility Fall/Winter menu for Monday, December 08, 2025, included Sweet and Sour Pork Saute, Sugar Snap Peas.On December 08, 2025, at 12:15 PM, the food temperatures were taken for the lunch meal. V5 (Director of Dietary) stated that meal service had started at 12:00 PM.The pureed sweet and sour pork showed 111.5 degrees Fahrenheit, and the pureed snap peas showed 122.5 degrees Fahrenheit. On December 08, 2025, at 12:23 PM, V6 (Cook) stated that he prepared the pureed items at around 10:00AM. On enquiry on how he prepared these items, V6 stated that he pureed the cooked sweet and sour pork and sugar snap peas respectively in a blender and had added a little hot water and thickener during the pureeing process. V6 stated that he then placed the items directly on the steam table. V6 stated that the hot water (in the steam table) may not have been hot enough to keep these pureed items warm. V6 added that he did not reheat the above pureed items.On December 08, 2025, at 2:13 PM, V9 (Dietitian) stated that the foods should be at minimum of 135 degrees Fahrenheit at the steam table. V9 stated that the pureed recipes should be followed during preparation of the same. Recipe for pureed Pork Saute Sweet and Sour showed as follows: Measure amount of cooked sweet and sour pork to be pureed in a food processor. Process until smooth in consistency. Pour into steam table pan coated with liquid food release. Keep hot for service. Critical Control Point: Hot foods held for later service must maintain internal temperature of 135 degrees Fahrenheit. Recipe for Pea's Sugar Snap Pureed Thick showed as follows: Remove portions to be pureed from the regular prepared vegetable. Place in food processor and process until fine in consistency. Gradually add food thickener and melted margarine to the vegetables while processing. Scrape down sides of processor with a rubber spatula and process for seconds. Heat. Critical Control Point: Within 2 hours, Reheat to a minimum internal temperature of 165 degrees Fahrenheit for a minimum of 15 seconds. Hot foods held for later service must maintain internal temperature of 135 degrees Fahrenheit. Facility (undated) Policy titled Safe Food Preparation and Handling included:Policy: Food will be prepared to conserve maximum nutrition value in a safe and sanitary environment.Procedure: The following safe food preparation and handling practices will be followed:6. Foods will be held at proper temperatures. Hot food will be a minimum of 135 degrees Fahrenheit and cold food will be a maximum of 41 degrees Fahrenheit. Facility diet order listing printed on December 8, 2025, showed that R15, R19, and R24 were on pureed diets.