STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Living & Rehab Ctr	310 Banbury Road North Aurora, IL 60542

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 - Some	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 obtained from the pharmacy in a timely manner to prevent residents from missing medications doses as ordered by the physician. This applies to 4 of 4 residents (R1, R2, R3, and R4) reviewed for pharmacy services in the sample of 4.The findings include:1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, major depressive disorder, attention-deficit hyperactivity disorder, and borderline personality disorder. R1's MDS (Minimum Data Set) dated June 17, 2026, showed R1 was cognitively intact. R1's Physician Orders dated June 25, 2026, showed an order dated March 28, 2025, for diclofenac sodium 75 mg (milligram), delayed release, give one tablet by oral route two times per day. R1's April 2026 MAR (Medication Administration Record) showed on April 10, 2026, R1 did not receive the 9:00 AM dose of diclofenac. V8 (LPN/Licensed Practical Nurse) documented the reason as Other: awaiting delivery. R1's May 2026 MAR showed on May 31, 2026, R1 did not receive the 9:00 AM dose of diclofenac. V7 (LPN) documented the reason as Other: pending delivery. On June 24, 2026, at 12:26 PM, R1 said the facility has run out of his medications multiple times. R1 said most recently it was his diclofenac. R1 said when he misses doses of diclofenac it makes it difficult to ambulate. On June 24, 2026, at 2:58 PM, V3 (ADON/Assistant Director of Nursing) said sometimes staff reorder R1's medications from pharmacy too early and pharmacy won't refill the medication. V3 said the facility is not notified the medication refill request cannot be fulfilled due to the request coming too early. V3 said another request has to be sent but the facility is unaware the first request was denied. V3 said R1 has missed medications due to pharmacy not refilling his medications. V3 said a resident's scheduled medication should not be missed and it should be reordered so the refill comes before a dose is missed. 2. R2's EMR showed R2 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, depression, and anxiety disorder. R2's MDS dated [DATE], showed R2 was cognitively intact. R2's Physician Orders dated June 25, 2026, showed an order dated May 19, 2026, for clonazepam 0.5 mg tablet, give one tablet by oral route two times per day. R2's June 2026 MAR showed on June 22, 2026, R2 did not receive the 9:00 AM dose of clonazepam. V9 (RN/Registered Nurse) documented the reason the medication was not given as Other: medication on order awaiting delivery. On June 25, 2026, at 8:47 AM, R2 said the facility has run out of one of his medications and he missed a dose of the medication. 3. R3's EMR showed R3 was admitted to the facility on [DATE], with multiple diagnoses including paranoid schizophrenia, dementia, and atrial fibrillation. R3's MDS dated [DATE], showed R3 was cognitively intact. R3's Physician Orders dated June 25, 2026, showed an order dated September 23, 2025, for lorazepam 1 mg tablet, give one tablet by oral route once daily at bedtime. R3's June 2026 MAR showed on June 19, 2026, R3 did not receive the 9:00 PM dose of lorazepam. V10 (LPN) documented the reason as Other: Reordered. 4. R4's EMR showed R4 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease with dyskinesia, schizoaffective disorder, and drug induced subacute dyskinesia. R4's MDS dated [DATE], showed R4 was cognitively intact. R4's Physician Orders dated June 25, 2026, showed an order dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Living & Rehab Ctr	310 Banbury Road North Aurora, IL 60542

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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 - Some	February 13, 2026, for [Valbenzapine] 60 mg capsule, give one capsule by oral route once daily at bedtime. R4's June 2026 MAR showed on June 17, 2026, R4 did not receive the 9:00 PM dose of Valbenzapine. V11 (LPN) documented the reason as Other: Pharmacy to deliver. The MAR continued to show on June 19, 2026, R4 did not receive the 9:00 PM dose of Valbenzapine. V12 (RN) documented the reason as Other: pharmacy yet to deliver. On June 24, 2026, at 3:40 PM, V2 (DON/Director of Nursing) said the facility is not being made aware by the pharmacy when medication refill requests are being denied and then residents run out of medications. V2 said it is important for residents to receive their scheduled medications, and they should not miss medication doses.