STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000472	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLIGHT HEALTHCARE OF ROCHELLE	1021 CARON ROAD , ROCHELLE, Illinois, 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Second Probationary Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations ONE OF TWELVE 300.650a) 300.650c) Section 300.650 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements. c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to contact the Illinois Department of Financial and Professional Regulation (IDFPR) to verify an individual's license was active, failed to maintain a copy of nursing licenses within employee files. This applies to 2 of 3 nursing employee files reviewed for IDFPR and license checks in the sample of 3. The findings include: V7's (Licensed Practical Nurse) employee filed showed V7 was hired on 11/1/24. V7's IDFPR check was completed on 1/30/25 (90 days after V7 was hired). V6's (Registered Nurse) employee filed showed V7 was hired on 1/6/22. No IDFPR check or nursing license was	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 present in V6's employee file. On 8/13/25 at 8:31AM, V8 (Business office) stated, "(V6) worked here previously and then she has come back a few times, but I don't know all her dates of employment. I do check the IDFPR website, but I did not print out the form to prove that I looked it up. I didn't realize that I had to do it, but I will start printing it now. I cannot find any additional hire dates for (V6) so I don't know when she came back to the facility. Her hire occurred prior to me starting here." On 8/13/25 at 1:22PM, V2 (Director of Nursing) stated, "We definitely should be checking all of the background sites and registry sites for staff prior to them starting work at the facility. We need to ensure staff do not have any disciplinary actions on their license to ensure our residents are safe and we have the appropriate staff caring for them." The facility was unable to provide a policy regarding staff background checks. (C) TWO OF TWELVE 300.670a) 300.671c)1)2)3) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the	S9999		

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S9999	Continued from page 2 facility; and 3) Evaluate the effectiveness of disaster plans and procedures. These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide documentation of any completed or scheduled annual disaster evacuation drills. This failure has the potential to affect all 49 residents that currently reside in the facility. The findings include: The facility's "Resident List Report" dated 8/12/25 showed 49 residents residing in the facility. On 8/13/25, review of facility's emergency operations plan showed no documentation of any previously completed or planned disaster evacuation drills. On 8/13/25 at 1:53PM, V5 (Maintenance Director) said the previous maintenance director had misplaced documents and that he could not provide any documentation from prior to his start date on 7/7/25. V5 then said the facility hasn't done any disaster drills to date, then said he currently does not have an evacuation drill planned. Emergency Operations Plan-Drills and Exercises (PR-3) policy last revised 1/28/25 reads in part: Tabletop exercises, functional and full-scale exercises, including evacuation exercises, discussion based, and other forms of exercises are conducted to test the response capability of the Highlight Healthcare of Rochelle staff and test the emergency operations plan. Exercises ensure that all personnel are properly trained to respond to an actual emergency/urgent event. The exercises SHALL be done at least annually and dependent upon some Centers for Medicare and Medicaid (CMS) state regulations some may need to be conducted more often. The scenarios for these drills and exercises range from specific building evacuations to a simulated natural disaster and involve actions from all onsite personnel. The exercises should be as realistic as possible under the simulated disaster conditions. An After-Action-Review meeting will be held following the real event or exercise. A written report will be completed within a month post event After Action Plan (AAP) which will include the corrective action. The corrective action will be incorporated into the plan as soon as feasible.	S9999		

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S9999	Continued from page 3 Evacuation Partial, Internal, and Temporary (SOG-20) policy last revised 1/28/25 reads in part: The primary purpose of the Evacuation Plan is to provide a course of action and clear guidelines for personnel, residents, and patients to follow in the event of the need to evacuate or shelter-in-place. Procedure: It is important to note that each situation is different, and the procedure is a guideline and may not be implemented in specific order. All Personnel are authorized to take immediate action to rescue/evacuate or sheltering action in response to the event for life safety situations. (C) THREE OF TWELVE 300.700b)1) Section 300.700 Testing for Legionella Bacteria b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's" Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum: 1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system; This requirement was not met as evidenced by: Based on interview and record review, the facility failed to provide a description of the facility's water system that identified potential areas of Legionella growth, failed to perform a risk assessment to identify potential areas for Legionella growth. This applies to all residents residing in the facility. The findings include: The facility's "Resident List Report" dated 8/12/25 showed 49 residents residing in the facility. On 8/13/25 at 11:43AM, V5 (Maintenance Director) stated, "I started here on 7/7/25. I have done maintenance in some other facilities for a couple years. We don't have any areas of stagnant water in the building. I guess the only area that could have some would be in toilets and showers. We haven't performed a risk assessment. This is city water so if the city is	S9999		

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S9999	Continued from page 4 testing their water and it's fine then we wouldn't need to test our water." The facility's policy titled, "Water Management Program" dated 09/2024 showed, "It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens…in the facility's water system based on nationally accepted standards (e.g. ASHRAE, CDC, EPA)…2. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder. 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems…5. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water management program binder…" (C) FOUR OF TWELVE 300.686g)2) 300.686h)2) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medication g) Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker. (Section 2-106.1(b-3) of the Act) Additional informed consent is not required for changes in the prescription so long as those changes are described in the original written informed consent form, as required by subsection (h)(12)(A). The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome, pursuant to subsection (h)(12)(A). The most common side effects of the medications shall be described. In an emergency, a facility shall: 2) Present this documentation to the resident and the resident's representative or other surrogate decision maker no later than 24 hours after the administration of emergency psychotropic medication. (Section 2-106.1(b-3) of the Act)	S9999		

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S9999	Continued from page 5 h) Protocol for Securing Informed Consent for Psychotropic Medication 2) No resident shall be administered psychotropic medication prior to a discussion between the resident or the resident's surrogate decision maker, or both, and the resident's physician or a physician the resident was referred to, a registered pharmacist, or a licensed nurse about the most common possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. (Section 2-106.1(b-3) of the Act). This requirement was not met as evidenced by: Based on interview and record review, the facility failed to obtain consent from a resident or resident's representative prior to administering psychotropic medications. This applies to 2 of 6 residents (R1, R4) reviewed for psychotropics in the sample of 11. The findings include: 1. R1's electronic face sheet printed on 8/13/25 showed R1 has diagnoses including but not limited to peripheral neuropathy, schizoaffective disorder, bipolar II, and suicidal ideations. R1's physician's orders dated 7/17/25 showed, "Lorazepam 1mg (milligram) every 12 hours as needed for anxiety." On 8/12/25, R1's electronic medical record did not show a consent had been received for R1 to receive lorazepam. On 8/13/25, the facility provided a consent form for R1 to receive lorazepam 1mg every 12 hours as needed that was dated 8/12/25. 2. R4's electronic face sheet printed on 8/13/25 showed admission date of 3/3/14 with a past medical history not limited to: paranoid schizophrenia, ataxia & ataxic gait, dystonia, drug-induced subacute dyskinesia, myoclonus, and major depressive disorder. R4's care plan last completed on 5/16/25 reads in part: impaired cognition as related to anxiety and paranoid schizophrenia and requires use of psychotropic medications to manage mood and/or behavior issues. R4's active physician orders as of 8/13/25 indicated R4 has orders for the following psychotropic medications: give 0.75 milligrams (mg) of clonazepam orally at bedtime; give 5mg of diazepam orally four times a day; give 250mg of divalproex sodium (Depakote) extended	S9999		

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S9999	Continued from page 6 release orally two times a day; and give 2mg of trihexyphenidyl orally four times a day all with a start date of 5/1/23. Review of R4's electronic medication administration records from March 2025 through current documented that R4 received all the above named psychotropic medications continuously, as ordered. On 8/12/25, review of R4's medical record revealed no informed consent for either the divalproex sodium or trihexyphenidyl. On 8/13/25, facility provided an informed consent form signed by R4 for divalproex sodium (Depakote) that was dated 8/12/25. No other consents were provided or found in R4's medical record. On 8/13/25 at 1:22PM, V2 (Director of Nursing) stated, "Prior to administering any type of psychotropic medication, a resident or their representative should give us consent and we need to have the consent form signed within 24 hours if we receive verbal consent. These consent forms were missed but I'm sure we spoke with the resident or their power of attorney prior to administering these medications." The facility's policy titled, "Use of Psychotropic Medications" revised on 3/2025 showed, "It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint…9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase…11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.)…" (B) FIVE OF TWELVE	S9999		

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S9999	Continued from page 7 300.697a) Section 300.697 Infection Preventionists A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility's infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP. a) IPs shall complete, or provide proof of completion of, initial infection control and prevention training, provided by CDC or equivalent training, covering topics listed in subsection (b)(1) to the facility, within 30 days after accepting an IP position. Documentation of required initial infection control and prevention training shall be maintained in the employee file. This requirement was not me as evidenced by: Based on interview and record review, the facility failed to designate an Infection Preventionist during the time their Infection Preventionist was on medical leave. This applies to all residents residing in the building. The findings include: The facility's "Resident List Report" dated 8/12/25 showed 49 residents residing in the facility. On 8/13/25 at 1:10PM, V2 (Director of Nursing) stated, "I have been filling in for the infection preventionist since June. I am not an infection preventionist and I have not completed the course. I'm not sure exactly when our infection preventionist comes back. She has been out on maternity leave for quite a while." (B) SIX OF TWELVE 300.1060f) Section 300.1060 Vaccinations f) A facility shall document in the resident's medical	S9999		

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S9999	Continued from page 8 record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act). This requirement was not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were screened for risk factors for Hepatitis B, failed to assess if residents were immunized against Hepatitis B. This applies to 5 of 5 residents (R2, R6, R7, R8, R9) reviewed for immunizations in the sample of 11. The findings include: On 8/13/25, R2, R6, R7, R8, and R9's electronic medical records were reviewed and showed all residents had not received verbal assessments for risk factors for Hepatitis B nor where residents asked if they had received the Hepatitis B vaccines. On 8/13/25 at 12:58PM, V2 (Director of Nursing/Infection Preventionist) stated, "We do not do any Hepatitis B screening of our residents, and we never have. We didn't realize that was a requirement. I guess we will need to review the regulations to ensure we are following them from an immunization perspective. I can see where that would be important especially with our population to at least be screening residents for this and offering the vaccination. We have a policy for it, so we need to implement that policy." The facility's policy titled, "Hepatitis B Exposure Control" revised on 1/2025 showed, "It is the policy of this facility to establish procedures for controlling exposure to Hepatitis B…18. Residents "e 60 years without known risk factors who request Hepatitis B vaccination may receive the vaccines, subject to physician orders and informed consent. Note: vaccine response is decreased among older adults." (B) SEVEN OF TWELVE 300.1210a) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and	S9999		

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S9999	Continued from page 9 Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement was not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall prevention measures for a resident. This applies to 1 of 6 residents (R11) reviewed for falls in the sample of 11. The findings include: R11’s electronic face sheet printed on 8/13/25 showed R11 has diagnoses including but not limited to schizoaffective disorder, pseudobulbar affect, dementia with behaviors, anxiety disorder, and bipolar disorder. R11’s facility assessment dated 5/2/25 showed R10 has mild cognitive impairment, requires supervision for transfers, and is at risk for falls with 1 fall since admission with injury. The facility’s document titled “Fall Log” received on 8/12/25 showed R11 has had 2 falls within the past 3	S9999		

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S9999	Continued from page 10 months. R11's nursing progress notes dated 8/4/25 showed, "Nurse was alerted by other resident that this resident was in their room bleeding, this writer immediately got up to assess patient…Writer obtained warm wash cloths to assist in cleaning with patient. Upon assessment, resident had blood on nose, arms, and chest. Patient has obvious laceration on nose and eyebrow. Nose continues to bleed, no blood from eyebrow. Patient is alert and oriented x4, is able to answer questions appropriately, and has clear speech. Resident states they hit their head on their bedside table as they were reaching for an item. Roommate was asleep and not able to verify, no other residents witnessed. Patient agreeable to being seen by hospital staff, this writer called 911…" R11's nursing progress notes dated 8/5/25 showed, "Report was given from (local hospital) that resident is diagnosed with a closed fracture of the nasal bone. Resident was in stable condition when arrived back to the facility. Resident was educated to call for assistance if she needed to get any items off the floor to prevent any injuries…" R11's nursing care plan with a revision date of 8/10/25 showed, "(R11) is at HIGH risk for falls and injury. Risk factors include gait/balance problems, poor safety awareness, history of falling, cognitive impairment-does not understand limits, cognitive impairment-unaware of safety needs, medication-psychoactive drug use, poor balance, unsteady gait…chair and bed alarm." On 8/12/25 at 1:34PM, R11 was resting in her bed. R11 did not have an alarm clipped on her and her fall mat was folded up by her bedside table. R11's wheelchair was next to her bed, unlocked. On 8/13/25 at 11:25AM, R11 was wheeling herself around facility in her wheelchair. R11 was sitting at the edge of her wheelchair and had no alarm on her wheelchair. Surveyor went into R11's room and her alarm was sitting on her bedside table. On 8/13/25 at 11:34AM, V9 (Certified Nursing Assistant) stated, "(R11) has a floor mat that should be down whenever she is in bed and her bed is to be in the lowest position. I think she might have a chair alarm, but she doesn't have a bed alarm or anything like that." On 8/13/25 at 1:22PM, V2 (Director of Nursing) stated,	S9999		

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S9999	Continued from page 11 "(R11) has new fall prevention measures in place and the aides should be aware of those interventions because it should be communicated across all shifts. If the prevention measures are not in place, (R11) could have a fall or another incident like she had on 8/4." The facility's policy titled, "Fall Prevention Program" dated 11/2024 showed, "Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls…7. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed…" (B) EIGHT OF TWELVE 300.1640a) Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.) These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to maintain an unattended locked medication cart and for one of two medication carts reviewed. The findings include: On 8/12/25 at 1:30PM, V10 RN (Registered Nurse) left a medication cart she was working from unattended and unlocked while she walked all the way down a resident hallway. This medication cart was located in a central area of the facility frequently crowded with both residents and staff. The medication cart was unattended/unlocked for approximately 5 minutes. At approximately 1:35PM, V10 again left the medication cart unlocked/unattended when she walked toward the far side of the nursing station to obtain a blood pressure from R3. While obtaining R3's blood pressure, V10's back was toward the medication cart and not visible to	S9999		

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S9999	Continued from page 12 V10. At approximately 1:50PM, V10 locked the medication cart. At that time V10 was asked about leaving the medication cart unlocked, V10 confirmed that she had left the cart unlocked/unattended "at times." On 8/13/25 at 2:15PM, V2 DON (Director of Nursing) stated she was unaware that V10 had been leaving the medication cart unlocked/unattended. V2 stated she usually monitor new "Agency" nurses to ensure they are following nursing standards which would include never leaving a medication cart unlocked/unattended. V2 stated she did not have time to monitor V10. Facility Policy/Controlled Substances Administration and Accountability dated 5/2024 documents: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. (C) NINE OF TWELVE 300.2050f) Section 300.2050 Meal Planning Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the following Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. f) Other foods shall be served to round out meals, satisfy individual appetites, improve flavor, and meet the individual's nutritional and caloric needs. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure supplements were served to residents per physician orders and/or dietitian recommendations for three of six residents (R2, R4, R10) reviewed for nutrition in the sample of 11. This failure resulted in R10 experiencing a significant weight loss. The findings include:	S9999		

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S9999	Continued from page 13 1. Review of diet type report (dietary supplements) provided by V3 (Food Service Director) with a print date of 8/12/25 showed R4 is to receive a “magic cup” (nutritional dessert cup) and R10 is to receive a “mighty shake” (nutritional shake). R2 was not listed on this diet report. On 8/12/25 at 11:00AM, R4 said he used to receive mighty shakes but no longer receives them then said he has not received a magic cup in weeks. At 12:12PM, R4 was served lunch in the dining room. R4 did not receive a magic cup during lunch observation. R4's electronic face sheet printed on 8/13/25 showed admission date of 3/3/14 with a past a medical history not limited to paranoid schizophrenia, ataxia & ataxic gait, dystonia, drug-induced subacute dyskinesia, myoclonus, and major depressive disorder. R4’s active physician orders printed on 8/13/25 documented an order for magic cup two times a day for supplement with start date of 6/26/25. Review of R4’s electronic medication administration record for August 2025 showed R4 should receive a magic cup at 7:30AM and 5:00PM (1700). On 8/13/25, R4’s registered dietitian nutrition note with effective date of 6/23/25 read in part, “resident on a general double protein at breakfast with magic cup and super cereal at breakfast. Resident appears very thin…Body Mass Index 19.4 thin, underweight…Recommend discontinuing super cereal at breakfast and change magic cup to twice daily. Resident remains at risk…” On 8/13/25 at 10:40AM, R4 indicated that he did not receive a magic cup with his dinner on the previous night (8/12/25) or with breakfast this morning. On 8/13/25 at 11:39PM, V6 (Registered Nurse) said the kitchen provides the nutritional supplements (mighty shakes and magic cups) to the residents and the nurses document that the residents received the supplement on their medication administration record (MAR). V6 then said she doesn’t typically observe a resident consume their supplement but if no residents complain to her that they didn’t receive one, then she will just document that it was received on the MAR. 2. On 8/13/25 at 11:36AM, R10 said she is supposed to have shakes three times a day at meals but she does not always receive them. R10 then said she has experienced recent weight loss.	S9999		

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S9999	Continued from page 14 R10's electronic face sheet printed on 8/13/25 showed admission date of 6/26/24 with a past medical history not limited to anemia, protein-calorie malnutrition, anorexia, major depressive disorder, and anxiety. R10's active physician orders printed on 8/13/25 documented an order for mighty shake three times a day with start date of 3/24/25. Review of R10's electronic medication administration record for August 2025 showed R10 should receive a mighty shake at 7:30AM, 12:00PM and 5:30PM (1730). On 8/13/25, reviewed R10's registered dietitian nutrition note with effective date of 6/23/25 which read in part, "…Body Mass Index 16.6 underweight. Resident with significant weight loss, now stable. Recommend discontinuing shake 4 oz (ounce) bid (twice daily). Recommend shake 4 oz three times a day." Review of R10's weights for the last six months showed the following: 98.1 lbs. (pounds) on 8/8/25, 94.3 lbs. on 7/8/25, 93.9 lbs. on 6/4/25, 93.5 lbs. on 5/7/25, 96.1 lbs. on 4/1/25, 96.4 lbs. on 3/12/25. R10's weight change note with effective date of 5/13/25 reads in part, "noted resident with significant weight loss of 12% x 5 months (12.7 pounds)." 3. R2's electronic face sheet printed on 8/13/25 showed R2 has diagnoses including but not limited to cerebral palsy, major depressive disorder, epilepsy, schizoaffective disorder, paraplegia, and hypertension. R2's facility assessment dated 5/10/25 showed R2 has mild cognitive impairment. R2's dietitian recommendations dated 6/23/25 showed, "Nutritional shake daily." R2's nutrition progress note dated 7/31/25 showed, "Resident with treatment to coccyx pressure wound. He remains with nutritional interventions to include Juven bid (twice daily), prostat bid and a milk shake daily." R2's physician's orders for July 2025 and August 2025 showed no orders for R2 to receive a nutritional supplement. A list of all residents receiving nutritional supplements provided by the facility did not contain R2's name. On 8/13/25 at 9:29AM, R1 stated, "I don't take any supplements in the form of a shake. I don't even know	S9999		

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S9999	Continued from page 15 what those are. I would try them if they gave me one." On 8/13/25 at 1:22PM, V2 (Director of Nursing) stated, "That was my fault. I was in a hurry when I was entering the order, and I put it under his diet orders which doesn't populate for the nurses to check off that the resident received a shake. It also doesn't populate to the list of nutritional supplements for the dietary department to know to give R2 a shake, so he hasn't had one yet. (R2) has wounds and a history of weight loss so we need to make sure we are following the dietician's recommendations to aide in wound healing and maintaining his weight." Weight Monitoring policy last reviewed/revised 03/2025 reads in part: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. (B) TEN OF TWELVE 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." (Source: Amended at 49 Ill. Reg. 760, effective December 31, 2024) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately store food by not properly labeling and/or dating several food items; and failed to ensure the sanitizing solution was at the manufacture's recommended level. This failure affects all 49 residents who currently reside in the facility. The findings include: The facility's "Resident List Report" dated 8/12/25 showed 49 residents residing in the facility. On 8/12/25 at 9:52AM, observed V4 (Cook) wrap a quarter stick of butter in plastic wrap and place in the	S9999		

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S9999	Continued from page 16 refrigerator without an open/discard date. On 8/12/25 at 9:54AM, kitchen tour was conducted with V3 (Food Service Director). At 9:55AM, observed in the main refrigerator, one half pound of sliced American cheese wrapped in plastic wrap, a quarter stick of butter wrapped in plastic wrap, an opened gallon size of plastic container of mayonnaise, large bag of opened mixed salad, and small two plastic containers of salad dressing all without a label or open/discard date. On 8/12/25 at 10:00AM, observed in the main freezer, an opened plastic bag of breakfast sausage approximately one-third full that was not properly sealed and was not labeled or dated with an open/discard date. Also observed a small and opened plastic bag of diced green peppers, and a gallon-sized plastic bag filled with plain donuts with a large tear to one side of the bag, both without a label or open/discard date. On 8/12/25 at 10:02AM, V3 said food items should be labeled with open/discard dates to know the shelf life of the item and to ensure the food items are safe to eat. On 8/12/25 at 10:05AM, V3 tested the sanitizer solution level for a red bucket near the food prep sink area that read 100 ppm (parts per million). V3 indicated they use the “quat sanitizer” and the solution should be at 200 ppm’s to ensure safe sanitation levels. V3 added that the solution was just changed after breakfast. The facility’s undated dietary policy and procedures for “Food Storage” reads in part: food should be stored and prepared in a clean, safe sanitary manner that complies with state and federal guidelines to minimize bacteria…Food should be labeled and dated to monitor food safety… The facility’s undated dietary policy and procedures for “Cold Storage Areas” reads in part: cold food and beverages should be stored under safe and sanitary conditions…Date, label, and properly secure all products removed from original containers with all items labeled stating the contents inside, the date opened, and the appropriate use-by-date… The facility’s undated dietary policy and procedures for “Buckets, Red & Green” reads in part: …a red bucket with sanitizing solution must be available, changed at least three times, and in every prep area, throughout the workday to ensure food safety…for quat sanitizer, follow the manufacturer’s recommendations (test strip	S9999		

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S9999	Continued from page 17 200-400 ppm). Food Safety Requirements policy implemented 01/2025 reads in part: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety...Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage...Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and keeping foods covered or in tight containers. (C) ELEVEN OF TWELVE 300.2930a) 300.2930c)5) Section 300.2930 Plumbing Systems a) General Requirements. All plumbing systems shall be designed and installed in accordance with the requirements of the Illinois Plumbing Code (77 Ill. Adm. Code 890) except that the number of residents required water closets, lavatories, bathtubs, showers, and other fixtures shall be as required by this Part and the facility program. (B) c) Water Supply Systems 5) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. (A, B) These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure hot water temperatures did not exceed 110 degrees Fahrenheit to various locations and rooms throughout all three units. This failure directly affects R1, R2, R4-R9, and R11-R44. The findings include: The facility's "Resident List Report" dated 8/12/25 showed 49 residents residing in the facility and showed	S9999		

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S9999	Continued from page 18 that R1, R4-R6, R8, and R11-R24 reside on A hall and utilize unit bathrooms and shower rooms. R2, R9, and R25-R39 reside on B hall and utilize unit bathrooms and shower rooms. On 8/13/25, reviewed weekly water temperature logs provided by V5 (Maintenance Director) with the following elevated temperature readings in degrees Fahrenheit (F): Week of 8/10/25 through 8/16/25 showed A hall restroom at 113.9 degrees, A hall shower room sink at 115.5 degrees, R33-R35 room at 112.6 degrees, B hall restroom sink at 115.3 degrees, B hall shower room sink at 119.3 degrees, and R40, R41's room at 117.7 degrees. Week of 8/3/25 through 8/9/25 showed B hall restroom sink at 111 degrees and R40, R41's room at 115 degrees. Week of 7/27/25 through 8/2/25 showed B hall restroom sink at 111 degrees, B hall shower room sink at 114 degrees, and R40, R41's room at 115 degrees. Week of 7/21/25 through 7/27/25 showed A hall restroom at 111 degrees, B hall restroom sink at 114 degrees, R40, R41's room at 114 degrees and R43, R44's sink and shower both at 111 degrees. Week of 7/13/25 through 7/20/25 showed A hall restroom at 111 degrees, A hall shower room sink at 118 degrees, B hall restroom sink at 119 degrees, B hall shower room sink at 120 degrees, B hall shower room shower at 117 degrees, R40, R41's room at 114 degrees and R43, R44's sink and shower both at 112 degrees. Week of 7/6/25 through 7/12/25 showed A hall restroom at 117 degrees, A hall shower room sink at 118 degrees, B hall restroom sink at 119 degrees, B hall shower room sink at 120 degrees, B hall shower room shower at 117 degrees, R40, R41's room at 114 degrees, and R43, R44's sink and shower both at 112 degrees. On 8/13/25 at 1:53PM, V5 said the previous maintenance director misplaced documents, then said he cannot provide any water temperature logs from March 2025 through July 2025 and could only provide logs from his start date on 7/7/25 to current. At 2:46PM, V5 said he was not aware that water temperatures could not exceed 110 degrees because he thought there was a temperature range from 90-120 degrees. V5 then indicated he will drop the temps down and would provide current temperature readings. None were provided upon survey exit.	S9999		

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S9999	Continued from page 19 Safe Water Temperatures Policy last reviewed/revised 01/2025 reads in part: It is the policy of this facility to maintain appropriate water temperatures in resident care areas. Policy Explanation and Compliance Guidelines: Direct care staff will monitor residents during prolonged exposure to warm or hot water for any signs or symptoms of burns and will respond appropriately. Staff will be educated on safe water temperatures upon employment and on a regular basis. Thermometers will be available as needed for use by all staff. Staff will report abnormal findings, such as complaints of water too cold or hot, burns or redness, or any problems with water temperature (ex. water is painful to touch or causes redness) to the supervisor and/or maintenance staff. Water temperatures will be set to a temperature of no more than 110° F (43° C), or the state's allowable maximum water temperature. Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. Documentation of testing will be maintained for 3 years and kept in the maintenance office. (C) TWELVE OF TWELVE 300.1210b) 300.1210d)3) 300.1620f) 300.1630d) 300.1850h) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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S9999	Continued from page 20 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1620 Compliance with Licensed Prescriber's Orders f) The licensed prescriber shall approve the release of any medications to the resident, or person responsible for the resident's care, at the time of discharge or when the resident is going to be temporarily out of the facility at medication time. Disposition of the medications shall be noted in the resident's clinical record. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.1850 Other Resident Record Requirement h) The resident's medical record shall include notations indicating any release of medications to the resident or person responsible for the resident's care, as described in Section 300.1620(e) of this Part. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to notify the physician of a change of condition, failed to document location, time and return and failed to document the disposition of medications sent home with one resident (R3) who left the facility on therapeutic pass for one (R3) of 25 residents reviewed for medication administration. The findings include: Current Physician Order Summary Report indicates R3 has orders for Midodrine (anti-hypotensive) 5mg (milligrams) three times daily; hold if BP (Blood Pressure) above 120/80. On 8/13/25 at 1:35PM V10, Agency RN stated she needed to take R3's blood pressure as he was leaving to go out on a therapeutic pass and had not yet received his noon Midodrine (anti-hypotensive) medication. V10 reported	S9999		

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S9999	Continued from page 21 R3's blood pressure reading was 128/97 and R3's heart rate was 102. V10 stated R3's blood pressure was outside of the parameters ordered for the Midodrine and she would need to "Hold" the medication. V10 also stated R3's heart rate was "high." At that time, V10 continued to prepare R3's medication to send with R3 on his leave from the facility. V10 handed five pharmacy medication cards to R3 and one small baggie containing Vitamin C tablets. V10 gave no instruction related to R3's elevated blood pressure and heart rate and did not notify R3's physician for instructions. R3 then left the facility. Nurse Note dated 8/12/25 at 1:38PM indicates "Midodrine 5 MG Give 1 tablet by mouth three times a day for hypotension with meals (HOLD IF BP IS ABOVE 120/80). No other notes were found or presented to indicate V10 educated/instructed R3 related to elevated blood pressure, heart rate or medications. V10 did not document R3's condition when he left the facility, time R3 left the facility, when R3 was expected to return or that R3 left the facility with medications. Current Care Plan indicates R3 has focus problem of Hypotension with interventions to monitor R3's vital signs per facility protocol, physician orders and as indicated; Notify physician of significant abnormalities. Care Plan also indicates to provide education to R3 and/or family to include signs/symptoms which would indicate medical evaluation as necessary. R3's Care Plan does not indicate R3 has Therapeutic Leave privileges, or any interventions needed. On 8/13/25 at 2:15PM V2, DON (Director of Nursing) stated V10 should have notified R3's physician of R3's blood pressure, heart rate and that the Midodrine was held since R3 was leaving the facility for six days and we would not be able to monitor R3. V2 stated they also could have called R3 at home to see how he was doing. V2 also stated V10 "absolutely" should have documented about R3's vital signs, any signs/symptoms, resident condition, time R3 left the facility and that R3 left with medications. Facility Policy/Notification of Changes dated 9/20/23 documents: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.	S9999		

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HIGHLIGHT HEALTHCARE OF ROCHELLE	1021 CARON ROAD , ROCHELLE, Illinois, 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 22 Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances Requiring Notification Include: 1. Circumstances that require a need to alter treatment. This may include: New treatment; Discontinuation of current treatment due to: Adverse consequences; Acute condition; Exacerbation of a chronic condition. Facility Policy/Therapeutic Out on Pass Privileges to Community dated 11/1/2024 documents: 1. Purpose: Establish guidelines for residents' therapeutic out-on-pass privileges to ensure their safety and well-being in the community. F. Physician Notification The physician may also be notified of any changes in the resident's condition or behaviors that can affect his or her therapeutic pass privileges. G. Nurse Responsibilities The nurse will document in the resident's medical record indicating that the resident went out on pass and when the resident returns from the facility. (B)	S9999		