STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E579	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Sterling	3601 Sixteenth Avenue Sterling, IL 61081

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** 39543 Based on observation, interview, and record review the facility failed to ensure medications were administered in accordance with manufacturer's directions; failed to monitor residents during medication administration; and failed to provide ordered medications. This applies to 2 of 3 residents (R21 & R26) reviewed for medication administration in the sample of 13. The findings include: 1. R21's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include high triglycerides (a specific type of fat found in the blood); bipolar; and schizoaffective disorder. R21's Order Summary Report (Physician Orders, as of 5/7/24) showed an order for Icosapent Ethyl (medication to treat high triglycerides and reduce the risk of cardiovascular disease) to be given twice daily. The order showed it was started on 8/31/23 and the order was active. On 5/7/23 at 8:20 AM, V4 Licensed Practical Nurse (LPN) administered R21's morning medications. V4 failed to provide R21 his Icosapent Ethyl. V4 stated the medication was not available and it was also not available on her previous shift, which was 5/5/24. On 5/7/24 at 2:47 PM, V2 Director of Nursing (DON) stated R21's insurance denied payment for his Icosapent Ethyl medication. V2 stated the insurance company wanted R21 to be switched to an alternative medication. V2 stated she faxed the denial letter to V6 R21's physician on 3/6/24. V2 stated she spoke with V6 regarding the denial of payment and V6 stated the alternative medication would not work for R21. V2 said V6 wanted R21 to continue the Icosapent Ethyl medication. V2 stated R21 has not had Icosapent Ethyl since March 2024. V2 stated R21 has a diagnosis of high triglycerides and Icosapent Ethyl is to treat that condition. V2 stated if a medication is not available the physician should be notified, and the notification should be documented. R21's March 2024, April 2024, and May 2024 (As of 5/7/24) Medication Administration Records (MAR) showed the last documented dose of Icosapent Ethyl was given on 3/6/24. R21's 3/1/24 through 5/7/24 progress notes showed no documented notification of V6. (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
	14E579	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Sterling	3601 Sixteenth Avenue Sterling, IL 61081

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	The facility's Medication Administration Policy (Revised 11/18/17) showed .If a medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available .Notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason . 2. R21's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include high blood pressure, bipolar, and schizoaffective disorder. R21's Order Summary Report (Physician Orders, as of 5/7/24) showed an order for hydrochlorothiazide to be given daily to treat high blood pressure. On 5/7/24 at 8:20 AM, V4 Licensed Practical Nurse (LPN) was administering R21's medications. V4 dispensed all R21's morning medications into a plastic medicine cup. While V4 was looking at her charting, R21 swallowed his medications and threw the medicine cup away; however, a small peach colored pill remained and was thrown away by R21. V4 did not witness this. V4 then proceeded to dispense the next resident's medications. On 5/7/24 at 8:33 AM, the peach-colored pill was found in the garbage. V4 stated she did not notice R21 had failed to take the medication. V4 stated the peach-colored pill was R21's hydrochlorothiazide. On 5/7/24 at 11:04 AM, V2 Director of Nursing stated nurses should monitor residents during medication administration to ensure the resident's take their prescribed medications. 3. R21's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include chronic obstructive pulmonary disorder (COPD, lung/breathing disease), bipolar, and schizoaffective disorder. R21's Order Summary Report (Physician Orders, as of 5/7/24) showed an order for a combination budesonide (steroid) and fumoterol (medication to open airways) inhaler to treat his COPD. On 5/7/24 at 8:20 AM, V4 Licensed Practical Nurse (LPN) was administering R21's medications. V4 gave R21 his inhaler, he self-administered the inhaler, then left the nurse's cart. V4 did not stop R21 and have him rinse his mouth. The inhaler instructions showed, After you finish taking [the combination inhaler], rinse you mouth with water. Spit out the water. Do not swallow it. On 5/7/24 at 11:04 AM, V2 Director of Nursing stated V4 should have instructed R21 to rinse and spit after taking his combination inhaler. V2 said the purpose of rinse and spit is to prevent fungal infections in the mouth. V2 said nursing staff should follow manufacturer instructions for the resident's medications. 4. R26's Admission Record (Face Sheet) showed diagnoses to include of diabetes, long-term use of insulin, and depression. R26's Order Summary Report showed, as of 5/7/24, an order for 10 units of Lispro Insulin (fast acting insulin) to be injected twice daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E579	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Sterling	3601 Sixteenth Avenue Sterling, IL 61081

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	On 5/7/24 at 7:56 V4 Licensed Practical Nurse (LPN) prepared R26's prefilled multiuse insulin syringe (commonly referred to as an insulin pen). V4 attached the needled to the pen and dialed in 10 units. V4 did not wipe the tip of the pen with an alcohol wipe, and she did not prime the pen. V4 injected the lispro into R26. The insulin pen manufacturer instructions showed, Step 1: pull the Pen Cap straight off .wipe the rubber seal with an alcohol swab. The instructions showed after the needle is attached, Prime before each injection. Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime the pen, turn the dose knob to select 2 units. Step 7: hold the ben with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8 . On 5/7/24 at 11:04 AM, V2 Director of Nursing stated V4 should have wiped the tip of the needle with alcohol to prevent infection and she should have primed the needle to ensure R26 received the correct dose of insulin. V2 stated nursing staff should follow manufacturer instructions for resident medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E579	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Sterling	3601 Sixteenth Avenue Sterling, IL 61081

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 33761 Based on interview and record review the facility failed to ensure RN (Registered Nurse) staffing data was accurately entered in the Payroll-Based Journal (PBJ) system. This applies to all 42 residents residing in the facility. The findings include: The Long-Term Care Facility Application for Medicare and Medicaid (CMS #671) dated 5/7/24 documents there are 42 residents residing in the facility. On 05/07/24 at 10:10 AM, V1 (Administrator) said, she is not sure what the problem with reporting is. V1 said, the issue may be that the corporate office, who is responsible for submitting the PBJ data, pulls punch codes from the time clock, but outside agency staff does not punch the time clock so those hours are not submitted. V1 said, it might also be how the time clock codes the nurses when they punch in. On 05/08/24 at 12:10 PM, V1 said, V17 (from the corporate office) is the person responsible for reporting the PBJ, V1 said, V17 only works the weekends and only does reporting. V1 said, she does not have a phone number for V17, but did provide V17's email address. On 05/08/24 at 12:44 PM, this surveyor attempted to email V17 and received an immediate automatic reply that was blank. This surveyor requested V17 contact me before 5pm or tomorrow (5/9/24) between 7AM and 9AM and have gotten no response. The October 1-December 31st, 2023, PBJ Staffing Data Report shows, No RN hours, and failed to have licensed nursing coverage 24 hours a day, triggered. The nursing schedule was reviewed for that period and showed that there was RN and licensed nursing coverage as required. This shows the reporting was not accurate.