STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5104986	A. BUILDING: _____ B. WING _____	C 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITLEY OF AURORA (THE)	1340 RIVER STREET AURORA, IL 60506

(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) COMPLETE DATE
A 000	Initial Comment Complaint Investigation 2579692/IL00197886: 295.5000 cited	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: 295.5000 Type 2 violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) This requirement was not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's medications were administered according to physician's orders. This failure affects 1 of 3 residents (R3) reviewed for medication administration in the sample of 3. This failure creates a substantial probability of harm to a resident or residents.	A5000		

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A5000	Continued From page 1 The findings include: On 10/14/2025 at 11:10 AM, E3 (Licensed Practical Nurse) prepped R3's scheduled morning medications which included seven pills (acetaminophen 500 milligram (mg), cetirizine 10mg, hydralazine 10mg, metoprolol succinate 25mg, nephro-vite supplement, quetiapine 25mg, and vitamin b-12 250 microgram). E3 crushed each medication individually then poured the crushed medication into seven separate plastic med cups, added a small amount of vanilla pudding to each cup then mixed the pudding with the medication within each med cup. On 10/14/2025 at 11:16 AM, E3 said R3 also has an eye drop scheduled this morning (brimonidine 0.1%) but she could not find the bottle. E3 then said she will have to re-order more from the pharmacy. On 10/14/2025 at 11:24 AM, observed E3 administer each medication to R3 from the individual med cups that contained the crushed medication mixed with pudding. Review of R3's physician's order report from 08/01/2025 - 10/14/2025 showed orders for the following: acetaminophen 500 milligram (mg) one tablet three times daily, cetirizine 10mg one tablet daily, hydralazine 10mg one tablet four times daily (hold if systolic blood pressure is below 140, give extra tablet if above 170), metoprolol succinate 25mg one tablet daily (do not crush), nephro-vite supplement one tablet daily, quetiapine 25mg one tablet daily, vitamin b-12 250 microgram (mcg) one tablet daily and one eye drop: brimonidine solution 0.1% 1 drop to each eye twice daily.	A5000		

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A5000	Continued From page 2 On 10/14/2025 at 11:33 AM, E3 documented on R3's administration record that the brimonidine eye drops were not available. On 10/14/2025, review of R3's electronic administration record for October 2025 showed that the brimonidine eye drops were not available on the 4th, 5th, 7th and 13th but were refused on the 1st - 3rd, 6th, 8th, and 11-12th. No documentation was recorded for the evening doses on the 9th and 10th. On 10/14/2025, further review of R3's October 2025 administration record showed metoprolol succinate 25mg was not available on the 11th; melatonin 3mg was not available on the 7th and 13th; sertraline 25mg and 75mg tablets were not available on the 5th, 7th, 12th and 13th. Review of R3's physician's order report from 08/01/2025 - 10/14/2025 also showed orders for melatonin 3mg daily at bedtime, and sertraline 25mg with 50mg tablet to equal 75mg daily in the evening. On 10/14/2025 at 1:08 PM, E2 (Director of Healthcare) said residents receive their medications from either the facility pharmacy, veteran's affairs or their family brings them in. If family provides and is running low, the nurse is to inform the family. E2 added that some resident's meds are delivered to the facility and every two weeks, she does inventory of the resident's meds re-orders what is needed. E2 indicated she was not aware that R3's eye drops were not available or of any missed doses. E2 then said that medications should be administered as ordered during their scheduled administration times on the electronic medication administration record. E2 indicated the administration times are from 05:00	A5000		

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A5000	Continued From page 3 AM - 10:59 AM, 11:00 AM - 03:59 PM, and 04:00 PM - 07:59 PM. On 10/14/2025, requested from facility, R3's preferred pharmacy, last order date for brimonidine eye drops and last received date. Documentation was not provided by E1 (Executive Director) or E2 upon exit. Undated "Assistance with Medication" policy provided by facility on 10/14/2025 reads in part: medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so ... The licensed nurse is aware of an indication for the resident receiving medication, usual dose, parameters and routes, contraindications, allergies, sensitivities, and side effects. Administration of medication to be performed by a licensed nurse. Re-ordering refills is to be done by the nurse or physician for residents who use the communities preferred pharmacy ...	A5000		