STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Aurora	1017 West Galena Boulevard Aurora, IL 60506

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 0628 Level of Harm - Actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a resident's discharge correctly for 1 of 3 residents (R2) reviewed for discharge. This failure resulted in R2 losing his Medicare coverage from [DATE]-[DATE], having to cancel important diagnostic testing and a follow-up appointment with his neurosurgeon, not having CPAP (continuous positive airway pressure) supplies due to lack of medical coverage, and having to spend many hours and days trying to get his Medicare coverage reinstated.The findings include:R2's admission Record, printed by the facility on [DATE], showed he had diagnoses including, but not limited to partial intestinal obstruction, type II diabetes mellitus with hyperglycemia, gastrointestinal hemorrhage, anemia, acute kidney failure, neoplasm of unspecified behavior of bone, soft tissue, and skin, long-term use of non-insulin antidiabetic drugs, hypertension, anuria, and oliguria (reduced urine output or complete absence of urine output). The admission Record showed R2 was discharged to home on [DATE]. R2's progress note, dated [DATE], showed R2 was discharged to home with his wife (V9). R2's Oder Summary Report, provided by the facility on [DATE], showed an order for blood glucose checks daily. The report showed Patient may discharge to home [DATE] with orders for Home Health care services to be provided by (name of home health services company) for PT/OT, Nursing, CNA, and DME (medical equipment) to include a wheelchair. The Report also showed needs appointment in [DATE] for MRI per neurosurgeon.R2's Progress Note, dated [DATE], showed R1 transported home with wife via (transportation service) at 10:15 AM.The facility's Admission, Discharge, and Transfer Report, printed by the facility on [DATE], lists R2 as deceased .On [DATE] at 8:35 AM, R2 said he discharged from the facility to home on [DATE]. R2 said he had to cancel his scheduled MRI (Magnetic Resonance Imaging) and an appointment with his neurosurgeon, due to the facility putting him down as deceased , causing him to lose his Medicare coverage. V9 (R2's wife) was also on the phone and said R2 was not able to schedule any appointments to have his stage 1 pressure ulcer looked at, adding he has a lot of medical issues and needs to see his doctors. V9 said she kept a log of everything and would email IDPH (Illinois Department of Public Health) the specific details of everything they had to do to get the facility's error resolved. On [DATE] at 5:11 PM, V9 sent an email to IDPH that described the difficulties R2 encountered as a result of the facility incorrectly documenting R2's discharge as deceased .On [DATE] at 3:02 PM, V9 sent an email to IDPH with an update showing R2's Medicare account was active as of today. On [DATE] at 5:01 PM, V9 said, The facility error has taken up a lot of our time and has been very stressful on him. R2 agreed. We have been through a lot. (R2) and I have not been able to do anything because they have been on the phone trying to get it taken care of. (R2) was going to ask his neurosurgeon at his next appointment about an order for therapy, but the appointment had to be canceled due to the facility entering (R2) as deceased . Medicare would not cover the cost for (R2's) lancets and glucose test strips because the facility marked him as deceased . (R2) ran out of his CPAP (continuous positive airway pressure) supplies, and had to sleep without his CPAP for about 30 days, because he did not have the supplies. He did have trouble sleeping. R2 agreed. V9 said, (R2) was so mad because the facility was not returning our calls. It was very frustrating. He missed the MRI scheduled for [DATE] and the follow-up appointment on [DATE]. They had to be cancelled due to facility's mistake. (R2) just found out yesterday that it has finally been resolved, and (R2's) Medicare was reinstated. [NAME] departments from the hospital kept calling us and asking when the issue was going to be resolved so they could resubmit their claims. (R2) and I were told the date the facility's error went through the system on [DATE]. If we wanted to schedule any appointment, they would tell us we had to pay up front. We can't afford to do that. That is what we are paying the insurance company for. We felt the facility did not care about us. Like we were not important, like trash. No one should have to go through that.On [DATE] at 1:44 PM, V15 (Regional Business Manager for the facility) said, The nurse that discharged (R2) entered him into PCC (the facility's electronic medical record charting system) as discharged expired. We take that information from PCC, and that is how we enter it for billing purposes. V15 said she was notified on [DATE] that R2 went to make an appointment recently, and that is when R2 and V9 found out about the error. V15 said she was informed R2 missed a neuro appointment and some kind of test for his neuro appointment. V15 said she contacted Medicare and informed them that was an error. V15 said she contacted R2 and V9 to inform them it was corrected and would take about 7-10 business days. V15 said yesterday ([DATE]) was business day 4. V15 said she informed R2 if it has not been corrected by Tuesday, to give her a call and she would take care

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interview and record review, the facility failed to ensure dressing changes were done as ordered (R1), and failed to ensure weekly wound assessments and documentation of the assessments were completed, for 2 of 5 residents (R1, R4) reviewed for non-pressure wound care in the sample of 6.This failure resulted in R1's wound getting a maggot infestation, and the wound dehiscing and getting infected. R1 was sent out to a local emergency room, diagnosed with osteomyelitis, requiring two intravenous (IV) antibiotics to prevent sepsis, surgical intervention, and critical care hospital admission. This failure resulted in an Immediate Jeopardy.The Immediate jeopardy began on 7/3/2025 when the facility failed to do the dressing change as ordered and failed to assess R1's surgical site and document an assessment. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 7/16/2025 at 12:16 PM. The surveyor confirmed by observation, record review, and interview, that the Immediate Jeopardy was removed on 7/17/2025, but noncompliance remains at Level Two, because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include: 1. R1's admission Record, provided by the facility on 7/10/2025, showed she had diagnoses including, but not limited to, transient cerebral ischemic attack (stroke), atherosclerotic heart disease, aneurysm of the ascending aorta without rupture, myocardial infarction (heart attack), cellulitis of unspecified part of limb, and hypertension.R1's Discharge Instructions from a local hospital, dated 6/26/25, showed Wound Care: Dressing to be left in place until seen in the office next week. Do not get wet. R1's 7/1/2025 notes from the follow up appointment showed Wound cleansing and dressings. Dry protective dressing. Do not get wet. The document showed V4 (LPN) clarified the order to be done every other day.R1's Order Summary Report, provided by the facility on 7/10/2025, showed an order, dated 7/1/2025, for Wound #3 right toes area of great toe, 2nd toe, 3rd toe. Wound cleansing and dry protective dressing to be changed every other day. R1's July 2025 Treatment Administration Record (TAR) showed no treatment was documented as being completed from 7/2/2025-7/6/2025.The facility's weekly Skin Condition Report, dated 7/4/2025, showed R1 had arterial ulcers to her right posterior leg, right medial great toe, right second toe and her right third toe. V3 said the measurements on the form were taken from notes from the wound clinic R1 goes to.R1's Progress notes from 7/1/2025-7/5/2025 do not document any dressing change to the surgical site on R1's right foot/toes area. The progress notes only show RLE ((right lower extremity) wound documentation, which was a different wound on R1's right posterior lower leg. There was no documentation of a dressing change or assessment to R1's right foot surgical site until 7/6/2025 at 8:20 PM where it showed, Resident noted with an excessive amount of exudate drainage and possible presence of larvae in wound during wound care. MD (doctor) made aware and gave orders to send resident out for further eval (evaluation).R1's progress note, dated 7/6/2025 at 9:20 PM, showed R1 was noted with an excessive amount of exudate drainage and possible presence of larvae in wound during wound care, Doctor made aware and gave orders to send resident out for further evaluation. when an excessive amount of drainage and larvae were found on R1's right foot surgical wound and she was sent to a local hospital. R1's progress notes from 7/1/2025-7/6/2025 do not show any documentationR1's 7/6/2025 Emergency Department Physician Report from a local hospital showed, Right foot with multiple toe amputations, extensive wound at distal tip with sutures, wound dehiscence, necrotic tissue, copious maggots cleaned from wound, mild surrounding erythema with warmth. the notes showed, admission is required due to the severity of the right foot wound infection with suspected osteomyelitis, need for IV antibiotics, and risk of clinical deterioration. The notes showed Critical Care Statement: Given the patient's presentation with a right foot wound infection and osteomyelitis, which carried a high-risk for rapid clinical deterioration due to potential progression to severe sepsis or septic shock. The emergency room doctor provided 40 minutes of critical care time exclusive of other billable procedures. this time was spent in direct patient care involving high-complexity medical decision making and required constant attendance to prevent sudden, significant deterioration in the patient's condition. The Podiatry Consultation Physician's Report, dated 7/7/2025, showed R1 had surgery approximately two weeks ago due to amputation of the first, second, and third digits of the right foot. This was due to gangrenous changes due to severe peripheral arterial disease. Patient was seen in the office for follow-up and incision site looked good with the wound edges well coaptated and sutures in place. Patient presented to the emergency room last night with dehiscence of the wound and maggots in the wound. The physician debrided the wound and the maggots out. The notes showed R1 was started on IV antibiotics and admitted for further workup. V6's

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to perform a pressure risk screen for a resident (R6) at risk for developing pressure ulcers, failed to ensure pressure-reducing interventions were implemented correctly for one resident (R6), and failed to perform weekly facility wound assessments for one resident (R5). These failures affected two of three residents (R5, R6) reviewed for pressure ulcers in the sample size of 6.Findings include:1. R6's face sheet documented an admission date of 11/07/2024, with a past medical history not limited to: hemiplegia and hemiparesis, aphasia, hypertension, type 2 diabetes mellitus and chronic kidney disease. Brief Interview for Mental Status (BIMS), dated 05/23/2025, indicated R6 has moderate cognitive impairment, with a score of 11/15.R6's care plan, with review start date of 05/27/2025, documented R6 is an extensive assist too dependent with activities of daily living (ADL's); has had pressure ulcer development related to disease process and impaired mobility; and has a wound to sacrum, and right/left buttock. Care plan interventions for R6 included but not limited to the following: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning and follow facility policies/protocols for the prevention/treatment of skin breakdown. Weekly pressure ulcer and unstageable pressure ulcer report, dated 07/07/2025, documented R6 acquired at facility on 05/29/2025, an unstageable pressure ulcer to the left buttock, with current measurement of 6. 8x4.8x2.8 (length x width x depth) in centimeters, and an unstageable pressure ulcer to the right buttock with current measurement of 3.8x1.8x0.6 in centimeters; and acquired at facility on 07/07/2025, a stage two pressure ulcer to sacral region, with no measurements documented.R6's last documented weight on 07/14/2025 at 11:42 AM indicated weight of 148.6 Lbs.Review of R6's clinical assessment log on 07/16/2025 at 11:30 AM showed no pressure ulcer risk assessment (Braden) on file. On 07/15/2025 at 10:24 AM, 07/16/2025 at 10:57 PM, and 07/17/2025 at 10:35 AM and 12:15 PM, R6 was observed lying in bed on his back and wearing an incontinent brief. Low air loss mattress was in place and set to 350 pounds. R6 was also observed to be lying on top of two incontinent pads and the air mattress was covered with a cotton bottom sheet. R6 was alert to self and not interviewable.R6's active physician orders as of 07/16/2025 included to cleanse left and right buttock wounds with a topical antiseptic (dakins), apply calcium alginate and medical honey then cover with borderer gauze and to cleanse sacral wound with a topical antiseptic (dakins), apply medical honey then cover with borderer gauze daily and as needed. admitted to hospice on 07/12/2025.On 07/17/2025, facility presented a pressure ulcer risk assessment for R6, dated 07/16/2025 at 12:08 PM.2. R5's face sheet documented admission date of 07/15/2024, with a past medical history not limited to: paraplegia, traumatic brain injury, and neuromuscular dysfunction of the bladder. Brief Interview for Mental Status (BIMS), dated 05/01/2025, indicated R5 had no cognitive impairment.R5's pressure ulcer risk assessment (Braden), dated 04/10/2025, indicated resident is at moderate risk for developing a pressure ulcer. Weekly pressure ulcer and unstageable pressure ulcer report, dated 07/07/2025, documented R5 acquired at facility on 12/21/2025, and a pressure ulcer to the sacral region with current measurement of 3. 5x3.0x0.1 in centimeters and an unstageable pressure ulcer to the right buttock with current measurement of 3.8x1.8x0.6; and acquired at facility on 07/07/2025, a stage two pressure ulcer to sacral region, with no measurements documented.On 07/15/2025 at 10:12 AM, R5 was observed in room seated in a wheelchair watching television. R5 said he goes out on Mondays to a wound clinic every two weeks and receives daily wound care at the facility between visits to wound clinic. R5 then added the wound nurse has never measured or assessed his wounds until last week. R5 said he was shocked because his wounds have never been assessed at the facility, only done at the wound clinic. Review of R5's care plan on 07/15/2025 showed no documentation related to wounds or wound care. Facility presented undated care plan on 07/16/2025 for R5 that documented resident has actual impairment to skin integrity with current wounds to sacral, lateral right and left ankles. Interventions included but not limited to weekly treatment documentation to include measurement of each skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R5's active physician orders as of 07/16/2025 included to cleanse sacrum with normal saline/wound cleanser then apply (aquacel silver) dressing and cover with bordered gauze nightly and cleanse left lateral ankle with normal saline/wound cleanser then apply (aquacel silver) dressing and cover with absorbent bordered gauze dressing nightly every Monday, Thursday, and Saturday.On 07/11/2025 at 1:54 PM, V3 (Wound Nurse) said if a resident goes out for wound care, he does not perform a wound assessment and goes by the measurements and assessments done by the wound clinic. V3 added