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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Rochelle	1021 Caron Road Rochelle, IL 61068

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 35119 Based on interview and record review the facility failed to document the residents reason for discharge and failed to obtain physician documentation before discharging a resident for 2 of 3 (R10, R9) residents reviewed for discharge in the sample of 10. The findings include: 1. The facility's (Not part of medical record) Physical Aggression Initiated Report on R10 dated 11/20/24 shows writer observed resident agitated and yelling in hallway to staff members, writer and staff members asked if resident was alright writer ask resident if he needed assistance with anything trying to calm resident down with tone. writer observed resident grab object and throw towards staff while stating I missed on purpose resident is observed to have verbal aggression towards staff members while throwing objects directly onto staff member stating I'm going to kill them writer observed resident reach back with a closed fist and hit staff in eye resident continued yelling and pacing all resident near by was removed to safety writer phoned 911 resident was sent out. On 11/25/24 at 10:31 AM, V1 (Administrator) said R10 was having behaviors and R10 had punched her in her right eye. V1 said 911 was called and R10 was sent to the hospital. V1 said she left to seek medical attention herself and did not know if V11 (Registered Nurse) called the physician or not. V1 said V11 should have charted why R10 was being transferred. V1 said there should be physician orders to discharge in the medical record. R10's Physician Orders do not contain an order for discharge to hospital. R10's Progress Notes contains no documentation regarding resident being transferred to the hospital on 11/20/24, nor any physician documentation regarding the reason for transfer. On 11/25/24 at 11:45 AM, a message was left with V11, with no return phone call. On 11/25/24 at 12:12 PM, a message was left with V19 (R10's Primary Physician) with no return phone call. The facility's Transfer and Discharge Policy dated 11/2024 shows document assessment findings and other relevant information regarding the transfer in the medical record. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/25/24 at 1:12 PM, V1 said R9 was transferred to another facility. V1 said there was an agency nurse on duty that day and she was not sure if V19 (R9's Primary Physician) was called for discharge orders and did not see any orders. R9's Physician Orders do not contain an order for discharge to another facility. On 11/25/24 at 12:12 PM, a message was left with V19 (R9's Primary Physician) with no return phone call. On 11/25/24 at 1:37 PM, V17 (Social Services) said she was told V19 was notified but did not know for sure if V11 got discharge orders for R9. The facility's Transfer and Discharge Policy dated 11/2024 shows Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes: A final summary of the residents status. Supporting documentation will include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussion with the resident and /or resident representative.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 35119 Based on interview and record review the facility failed to notify a resident's guardian and the Ombudsman of a resident's involuntary discharge for 1 of 3 residents (R10) reviewed for discharge in the sample of 10. The findings include: The facility's (Not part of medical record) Physical Aggression Initiated Report on R10 dated 11/20/24 shows writer observed resident agitated and yelling in hallway to staff members, writer and staff members asked if resident was alright writer ask resident if he needed assistance with anything trying to calm resident down with tone. writer observed resident grab object and throw towards staff while stating I missed on purpose resident is observed to have verbal aggression towards staff members while throwing objects directly onto staff member stating I'm going to kill them writer observed resident reach back with a closed fist and hit staff in eye resident continued yelling and pacing all resident near by was removed to safety writer phoned 911 resident was sent out. On 11/25/24 at 10:31 AM, V1 (Administrator) said on 11/20/24, R10 was having behaviors and R10 had punched her in her right eye. V1 said 911 was called and R10 was sent to the hospital. On 11/25/24 at 11:02 AM, V1 (Administrator) said the facility had decided they weren't going to take R10 back on Thursday (11/21/24) and she told the hospital when they called on Saturday (11/23/24) that they were not going to take R10 back. On 11/25/24 at 11:28 AM, V9 (R10's Guardian) said the hospital told her on Sunday (11/24/25) the the facility was not going to take R10 back. V9 said the facility has not called her to let her know and she was very upset that they won't take R10 back. V9 said the facility needs to give her notice. On 11/25/24 at 1:12 PM, V1 said she had not notified V15 (Ombudsman) or V9 of R10's involuntary discharge. On 11/25/24 at 2:11 PM, V15 (Ombudsman) said she was not notified of R10's involuntary discharge. V15 said she should be notified of any discharge. R10's Progress Notes do not contain documentation that V9 or V15 were notified that R10 was not going to be admitted back to the facility. The facility's Transfer and Discharge Policy dated 11/2024 shows In situations where the facility had decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of State Long-Term Care Ombudsman. Notice to the Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 35119 Based on interview and record review the facility failed to allow a resident to return to the facility after a hospital stay and failed to document the reason for the refusal for 1 of 3 residents (R10) reviewed for discharge in the sample of 10. The findings include: The facility's (Not part of medical record) Physical Aggression Initiated Report on R10 dated 11/20/24 shows writer observed resident agitated and yelling in hallway to staff members, writer and staff members asked if resident was alright writer ask resident if he needed assistance with anything trying to calm resident down with tone. writer observed resident grab object and throw towards staff while stating I missed on purpose resident is observed to have verbal aggression towards staff members while throwing objects directly onto staff member stating I'm going to kill them writer observed resident reach back with a closed fist and hit staff in eye resident continued yelling and pacing all resident near by was removed to safety writer phoned 911 resident was sent out. On 11/25/24 at 10:31 AM, V1 (Administrator) said R10 was having behaviors and R10 had punched her in her right eye. V1 said 911 was called and R10 was sent to the hospital. R10's Progress Notes contains no documentation regarding resident being transferred to the hospital on 11/20/24, nor any physician documentation regarding the reason for transfer or the reason R10 is not being allowed to re-admit to the facility. On 11/25/24 at 12:12 PM, a message was left with V19 (R10's Primary Physician) with no return phone call. On 11/25/24 at 11:02 AM, V1 (Administrator) said the facility had decided they weren't going to take R10 back on Thursday (11/21/24) based on safety concerns and she told the hospital when they called on Saturday (11/23/24) that they were not going to take R10 back. On 11/25/24 at 11:24 AM, V1 said she had not started any involuntary discharge paperwork for R10 yet she was waiting for corporate. V1 said there was no documentation on R10's not being able to return to the facility. On 11/25/24 at 11:28 AM, V9 (R10's Guardian) said the hospital told her on Sunday (11/24/25) the the facility was not going to take R10 back. V9 said the facility has not called her to let her know and she was very upset that they won't take R10 back. On 11/25/24 at 1:46 PM, V10 (Hospital Nurse) said she called the facility on Saturday (11/23/24) that R10 could be discharged on a safely plan and did not require acute placement and the facility staff said he was not coming back. V10 said she spoke with V1 on Sunday (11/24/24) and was told R10 was not welcome back to the facility. V10 said she has not received any involuntary discharge paperwork for R10. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Transfer and Discharge Policy dated 11/2024 shows In situations where the facility initiates discharge while the residents still in the hospital following and emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility meets one of the specified exemptions- a. The transfer or discharge is necessary for the resident's welfare and the residents needs cannot be met in the facility.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 Based on interview and record review the facility failed to implement discharge planning for 1 of 3 residents (R9) reviewed for discharge in the sample of 10. The findings include: On 11/25/24 at 1:12 PM, V1 (Administrator) said R9 was transferred to another facility. V1 said V14 (Ombudsman) talked to R9 and came out to us and said the resident wanted to transfer to another facility. V1 said she spoke with R9 and he said he had family close by that facility. On 11/25/24 at 1:52 PM, V14 (Ombudsman) said she was at the facility and talked to R9. V14 said R9 said he wanted to transfer to a facility closer to his family. V14 said she told the facility staff but there was no discharge planner at the facility that day. V14 said V18 (Agency Registered Nurse) was working and she didn't know anything about discharging a resident. On 11/25/24 at 2:02 PM, V18 (Agency Registered Nurse) said on 11/8/24 she had been at lunch and when she returned, R9 was headed out the door transferring to another facility. V18 said V14 had talked to R9 and said he wanted to go to another facility. V18 was not sure what discharge arrangements had been made or what R9's discharge needs were. V18 said she was not sure V11 (Registered Nurse) had called the doctor or called and gave a report to the accepting facility. On 11/25/24 at 11:45 AM, a message was left with V11 with no return call. On 11/25/24 at 1:37 PM, V17 (Social Services) said there was no discharge planning done for R9, he had just admitted to the facility on [DATE]. V17 said there had been no interdisciplinary team meeting to discuss R9's discharge needs. V17 said on 11/8/24, she was told that R9 wanted to be transferred and she helped arrange the transfer to the other facility. R9's Progress Notes on 11/25/24 from V17 shows resident discharged from facility at 12:00 PM via facility's transportation van. Physician notified. Resident will be admitted to another facility. There are no progress notes regarding R9's discharge plan or needs. R9's Progress Note on 11/25/24 from V11 (Registered Nurse) shows discharged . The facility's Transfer and Discharge Policy dated 11/2024 shows Anticipated Transfers or Discharges: Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer of discharge from the facility.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 35119 Based on interview and record review the facility failed to ensure a resident's discharge summary was complete for 1 of 3 residents (R9) reviewed for discharge in the sample of 10. The findings include: On 11/25/24 at 1:12 PM, V1 Administrator said R9 was transferred to another facility. V1 said the Ombudsman talked to R9 and came out to us and said the resident wanted to transfer to another facility. V1 said she spoke with R9 and he said he had family close by that facility. On 11/25/24 at 1:52 PM, V14 (Ombudsman) said she was at the facility and talked to R9. V14 said R9 said he wanted to transfer to a facility closer to his family. V14 said she told the facility staff but there was no discharge planner at the facility that day. V14 said V18 (Agency Registered Nurse) was working and she didn't know anything about discharging a resident. On 11/25/24 at 2:02 PM, V18 (Agency Registered Nurse) said on 11/8/24 she had been at lunch and when she returned, R9 was headed out the door transferring to another facility. V18 said V14 had talked to R9 and said he wanted to go to another facility. V18 was not sure what discharge arrangements had been made or what R9's discharge needs were. V18 said she was not sure V11 (Registered Nurse) had called the doctor or called and gave a report to the accepting facility. V18 said R9's paper chart and his medications were sent them with R9 to the other facility. On 11/25/24 at 11:45 AM, a message was left with V11 with no return call. On 11/25/24 at 1:37 PM, V17 (Social Services) said on 11/8/24, she was told that R9 wanted to be transferred and she helped arrange the transfer to the other facility. R9's Progress Notes on 11/25/24 from V17 shows resident discharged from facility at 12:00 PM via facility's transportation van. Physician notified. Resident will be admitted to another facility. R9's Progress Note on 11/25/24 from V11 (Registered Nurse) shows discharged . This same note does not contain documentation of R9's status, that the physician was notified by the nurse, that R9's medications were reconciled, or that report was called to the oncoming facility. R9's electronic medical record does not contain a discharge summary for R9's transfer to another facility on 11/8/24. The facility's Transfer and Discharge Policy dated 11/2024 shows A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent labs, radiology and consultation results. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. A final summary of resident status iii. Reconciliation of all pre-discharged medications with the resident's post-discharge medications(both prescribed and over the counter). iv. A post discharge plan of care that is developed with the participation of the resident, and there resident's representative which will assist the resident to adjust to his or her new living environment.