

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>35541</p> <p>Based on interview and record review the facility failed to provide medical records to a resident's guardian/power of attorney for healthcare (POA) upon verbal and written request for 1 of 3 residents (R1) reviewed for the right to access medical records in the sample of 3.</p> <p>The findings include:</p> <p>A Letters of Guardianship form dated 9/30/2020 showed V6 was appointed R1's legal guardian.</p> <p>A Power of Attorney for Healthcare (POA) form dated 4/15/2015 showed V6 was appointed R1's POA.</p> <p>R1's current care plan showed R1 was cognitively impaired related to her diagnoses of mild intellectual disability, bipolar disorder, and schizophrenia.</p> <p>On 3/24/25 at 4:44 PM, V6 (R1's Guardian/POA) stated she had been asking V1 Administrator for copies of (R1's) medical records for her restorative cares and oral cares for awhile now. At least since February (2025). V6 stated she asked V1 Administrator, via email in February 2025, to email her a release of information form for her to complete to request these medicals records but he never sent me one. V6 stated she again verbally requested copies of R1's restorative and oral cares medical records during R1's care plan meeting on 3/12/25 but still had not received the records.</p> <p>Emails dated 2/12/25, between V6 (R1's Guardian/POA) and V1 Administrator, showed V6 asked V1, twice, to email her a release of information form for her to complete to obtain copies of R1's restorative and oral cares medical records.</p> <p>R1's care plan note dated 3/12/25 showed a care plan meeting for R1 was attended by V1 Administrator, V2 Director of Nursing (DON), V6 (R1's Guardian/POA), V3 Social Services, V4 Registered Nurse (RN), and V5 Ombudman. The note showed V6 requested documentation related to R1's restorative and oral cares during the meeting.</p> <p>(continued on next page)</p>

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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/25/25 at 9:25 AM, V1 Administrator stated a resident or their legal representative may get copies of medical records after a written form (release of information form) is completed to request these medical records. V1 stated V6 (R1's Guardian/POA) had requested access to R1's restorative and oral cares medical records during the care plan meeting on 3/12/25 but, she asked for QA (quality assurance) documentation. I couldn't give her that due to confidentiality. V1 denied ever receiving an email from V6 requesting he send her a release of information form for her to complete to obtain copies of R1's medical records.</p> <p>On 3/25/25 at 8:00 AM, V5 Ombudsman stated V6 (R1's Guardian/POA) has been requesting documentation of restorative care and oral cares for a few month from (V1 Administrator). V5 stated V6 did not ask for QA documentation during R1's care plan meeting on 3/12/25. V5 stated V6 did ask for copies of R1's medical records related to restorative and oral cares during the meeting.</p> <p>On 3/25/25 at 9:41 AM, V4 RN stated in R1's care plan meeting, (V6) wanted documentation showing restorative and oral cares for (R1). I don't recall her asking for a QA spreadsheet. (V6) just requested to see some of the documentation from the medical record that showed she was getting these cares .</p> <p>The facility's Release of Medical Records policy dated August 2024 showed, Medical records will be released with a valid request and in accordance with state and federal laws . Upon request to access or obtain copies of the medical record, the facility should review the authorization to ascertain access rights to that person. Authority to access or release records is only granted by the resident or the resident's legal representative . The resident's record is accessible to him/her within 72 hours (excluding weekends and holidays) notice, following an oral or written request. The resident is encouraged to review the record in the presence of the attending physician or a representative of the facility. The resident may have designated a legal representative who can exercise the same rights as the resident. The resident or his/her legal representative may receive a copy of his/her record within 5 working days after the request has been made .</p>