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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Living & Rehab Ctr	310 Banbury Road North Aurora, IL 60542

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37232 Based on interview and record review the facility failed to schedule a follow up doctor appointment for 1 of 3 residents (R1) reviewed for quality of care in the sample of 10. The findings include: R1's Face Sheet showed a diagnosis of stress fracture of the left radius. On 3/27/25 at 9:50 AM, V6 (R1's Mother) said R1 broke her arm, and the facility did not schedule R1's follow up appointment. On 3/27/25 at 9:30 AM, V4 (Transportation Scheduler) said she schedules residents follow up appointments. V4 said R1's last orthopedic appointment was on 2/25/25 and R1 was taken by the facility's ADAPT (Psychosocial Rehabilitation) staff. V4 said R1 did not have a follow up orthopedic appointment scheduled. On 3/27/25 at 10:50 AM, V8 (Program Director for ADAPT) said an ADAPT staff took R1 to the orthopedic appointment on 2/25/25. V8 said the after visit summary paperwork indicated R1 was to have a follow up appointment scheduled on the week of March 17th. V8 said the after visit summary was given to V3 (Registered Nurse). On 3/27/25 at 10:55 AM, V3 said R1 was to have a follow up orthopedic appointment around March 17th. V3 said he was not sure if the appointment was scheduled and the after visit summary was given to V4. On 3/27/25 at 11:05 AM, V4 said she just received R1's after visit summary paper work from the 2/25/25 office visit and is now aware R1 needed a follow up appointment scheduled. V4 said she was unsure why R1's appointment was not scheduled. R1's orthopedic After Visit Summary dated 2/25/25 showed, Please make an appointment in 3 weeks for a follow up. The week of March 17th. R1's Progress Note dated 2/25/25 entered by V3 showed R1 returned from an orthopedic appointment, and R1 was to return to the orthopedic office around March 17th.

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: 14E306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on interview and record review the facility failed to maintain an accurate and complete medical record after discharge for 1 of 3 residents (R2) reviewed for medical records in the sample of 10. The findings include: R2's face sheet printed on 3/27/25 show R2 was admitted to the facility last 5/2/24 with diagnoses of depression and cellulitis. (discharged [DATE]) A document of Authorization for Disclosure of Protected Health Information (PHI) dated 2/27/25 requesting R2's entire medical record dated May 2, 2024 (date of admit) to [DATE] (date of discharge) On 3/27/25 at 1:44 PM, R2 said she discharged last December. She had requested her medical records from the facility last month (February). R2 said she got some records but it was not complete. R2 said she was told they have no more access to her records due to a new system R2 said she was wanting a copy of her complete medical records including her doctor's notes and list of medications to review. One of the things she was wanting to review was her antibiotics prescribed to her to treat her cellulitis. R2 said she was at the facility again this week still following up her records that she had requested last February. On 3/27/25 at 10:30 AM, V12 (Medical record staff) said R2 had requested a copy of her medical records. But we cannot provide her complete records since I do not have any access to PCC. (previous electronic health record system-EHR). V12 said she gave R2 a copy of what was in R2's paper chart that included old records. Another request from R2 of Authorization for Disclosure of PHI dated 3/26/25 requesting NP notes and Psychiatric Notes. On 3/27/25 at 9:15 AM V5 (Social Worker) said R2 was at the facility this week still looking and requesting for more medical records. She was specific with psych notes and NP notes. V5 said there were some psych notes that were emailed to her from the Doctor's office so she gave R2 copies of those records. On On 3/27/25 at 10:30 AM, V2 (Director of Nursing) said the facility used to have PCC. Then when we have new owners and they have changed the (EHR) system to Sigma Care. If we have to refer to old records for information we cannot do that since we have no access like physician order sheets, progress notes, MAR, MDS and careplans of discharged residents. On 3/27/25 at 1PM, V1 (Administrator) said he knew that residents records should be kept years after they are discharged . V1 said the new owner is coordinating with the old owners to gain access to PCC.