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	07/17/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for 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 meet the requirements for an emergency involuntary transfer and did not allow the resident to return to the facility.This applies to 1 of 3 residents (R1) reviewed for involuntary discharge in the sample of 3.The findings include:R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder, bipolar disorder, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. The EMR continued to show R1 was transferred to the local hospital on July 7, 2025, and did not return to the facility.R1's MDS (Minimum Data Set) dated June 17, 2025, showed R1 was cognitively intact, and R1 required partial assistance from facility staff for eating, oral hygiene, toileting hygiene, and personal hygiene. On July 15, 2025, at 2:54 PM, V2 (DON/Director of Nursing) said on July 7, 2025, R1 asked V2 for more food and V2 instructed R1 he already a double portion meal. V2 said she told R1 the doctor allowed double portions but R1 could not have extra snacks. V2 said R1 started cursing and then started trying to exit the facility. V2 said staff followed R1 out of the facility and R1 hopped a fence and went into the street. V2 said R1 grabbed a piece of wood about 12 inches long and threatened to kill staff or himself. V2 said she called emergency services, and the police showed up in two to three minutes. V2 said this started at about 1:15 PM, and R1 left for the hospital in the ambulance around 3:00 PM. V2 said when R1 was about to leave in the ambulance, she handed paramedics multiple copies of R1's Petition for Involuntary/Judicial admission and the Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents. V2 said on the same day around 7:00 PM, an ambulance company showed up to the facility with R1. V2 said the nurse on duty called V2 and V2 spoke with the ambulance drivers and told them R1 had been involuntarily discharged from the facility. V2 said she told the ambulance company to send R1 back to the hospital because R1 had been involuntarily discharged from the facility. V2 said she spoke with the emergency room charge nurse and was told R1 was cleared by their psychiatrist to be discharged from the hospital. V2 said she told the emergency room charge nurse R1 had been involuntarily discharged from the facility and needed to go back to the hospital. V2 said after some time, the ambulance company took R1 back to the local hospital.On July 15, 2025, at 4:09 PM, V1 (Administrator) said he spoke with R1's case worker at the hospital on July 11, 2025, and informed her R1 had been involuntarily discharged from the facility and could not return. V1 said the facility does not have a policy for involuntary discharge, the facility follows the regulations for involuntary discharge.R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated July 7, 2025, showed Emergency Transfer or discharge: Yes. Federal Proceeding. The facility admits private-pay and Medicare or Medicaid residents and is federally-certified and state licensed, or this facility admits only Medicare or Medicaid residents and is federally funded. This facility seeks to transfer or discharge you pursuant to the regulations of the Health Care Financing Administration for states and long-term care facilities, 42 CFR 483.15 ('federal regulations'). As recorded in your clinical record in accordance with Section 483.15 (c) of the federal regulations, the reason for this proposed transfer or discharge is: the safety of individuals in this facility in endangered, 483.15 (c)(1)(i)(C).A progress note dated July 14, 2025, at 10:55 AM, by V1 showed On Friday, July 11, 2025, [V10 (Hospital Social Worker)] from [local hospital] contacted [the facility] that [R1] will be returning to [the facility]. This writer informed [V10] that [the facility] served involuntary discharge to [R1] on July 7, 2025, and we can't take [R1] back due to the threat and risk he posed on himself and the other residents here at [the facility]. Writer informed [V10] that proper involuntary discharge documents were sent with ambulance with two copies. Resident 'own guardian,' physician and ombudsman have been notified. [V10] said that she needs a copy of the emergency eviction order notice. Writer explained that nursing home regulations doesn't have emergency eviction notice order and that regulation doesn't apply in nursing home. Writer informed [V10] that [R1]'s psychiatrist at [a different hospital] are willing to accept [R1]. Writer also informed [V10] that [a different nursing home] is willing to accept [R1]. Writer informed [V10] that [the facility] can and will send [R1]'s belongings either to [local hospital or to any place [R1] will go to. [V10] said that my information are incorrect. I explained that I am following the nursing home regulations and the conversation ended.A progress note dated July 14, 2025, at 2:37 PM, by V1 showed [V4 (Ombudsman)] called writer today regarding [R1]. [V4] said that she spoke to [V10] today, July 14, 2025. [V4] said that [V10] informed her that [R1] is coming back to [the facility]. I informed [V4] that is incorrect and [the facility] is not accepting [R1] back. I informed [V4] that [the facility] informed [V10] that we