STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002844	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLIGHT HEALTHCARE OF AURORA	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.615 f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. The REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure that Illinois Department of Corrections (IDOC) Sex Registrant searches were completed within 24 hours of admission for newly admitted residents. This applies to 3 of 10 residents (R40, R49, and R51) reviewed for criminal background checks in the sample of 20. The findings include: 1. The EMR (Electronic Medical Record) showed R40 was admitted to the facility on November 11, 2024.	S9999		

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The facility did not have any documentation to show that R40 was checked on the IDOC Sex Registrant search page within 24 hours of admission to the facility.

2. The EMR (Electronic Medical Record) showed R49 was admitted to the facility on April 1, 2025.

The facility did not have any documentation to show that R49 was checked on the IDOC Sex Registrant search page within 24 hours of admission to the facility.

3. The EMR (Electronic Medical Record) showed R51 was admitted to the facility on January 3, 2025.

The facility did not have any documentation to show that R51 was checked on the IDOC Sex Registrant search page within 24 hours of admission to the facility.

On April 18, 2025 at 2:32 PM, V24 (Regional Director of Operations) was asked if the facility had the requested IDOC background checks for R40, R49, and R51. V24 stated they submitted to the surveyor everything they had for the requested resident's background checks. V24 stated the facility does not have any paperwork or evidence to show these residents (R40, R49, and R51) were checked on the IDOC Sex Registrant website.

The facility's resident background check process policy showed that the facility will 1) run background checks, and 2) when there is a hit on the background check, the facility will request fingerprinting.

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S9999	Continued From page 2 (C) 2 of 3 300.625 c)2) Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. The REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure that finger printing was arranged for residents who had hits on their background checks. This applies to 2 of 10 residents (R49 and R158) reviewed for background checks in the sample of 20.	S9999		

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S9999	Continued From page 3 The findings include: 1. The EMR (Electronic Medical Record) showed R49 was admitted to the facility on November 14, 2024. The facility did not have any documentation to show that R49 had fingerprinting arranged after R49 had a hit on his CHIRP dated November 13, 2025. 2. The EMR (Electronic Medical Record) showed R158 was admitted to the facility on April 1, 2025 The facility did not have any documentation to show that R158 had fingerprinting arranged after R158 had a hit on his CHIRP dated March 29, 2025. On April 18, 2025 at 2:32 PM, V24 (Regional Director of Operations) stated the facility does not have any paperwork or evidence of fingerprinting being done or requested for R49 and R158. The facility's resident background check process policy showed that the facility will 1) run background checks, and 2) when there is a hit on the background check, the facility will request fingerprinting. (C) 3 of 3 300.1035 a)5) 300.1210 b)	S9999		

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Section 300.1035 Life-Sustaining Treatments
a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights.
5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

These requirements are not met as evidenced by:

Based on record review and interview the facility failed to perform CPR (Cardio-Pulmonary Resuscitation) correctly as per standards of practice, failed to call a code blue within the facility, and failed to call EMS system (911) for an unresponsive resident identified as a full code on the physician's orders in accordance with the Facility policy.

This applies to 31 of 53 residents (R1, R5, R10, R11, R13, R15, R17, R18, R19, R20, R23, R25, R29, R33, R36, R37, R38, R39, R40, R42, R44,

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R45, R47, R48, R49, R52, R53, R55, R158, R257 and R307) reviewed for code status and request CPR to be performed.

The Findings include:

The admission record showed R55 was admitted to the facility on January 30, 2025, with diagnoses of fracture of the right femur subsequent encounter for closed fracture with routine healing, hypopituitarism, type 2 diabetes, chronic diastolic congestive heart failure, obstructive sleep apnea and cerebral infarction due to embolism of the cerebral artery.

R55's progress note dated January 30, 2025, at 3:00 PM showed R55 was admitted for further rehabilitation, was a full code status and transferred from another SNF (Skilled Nursing Facility), R55's hospital referral notes to prior facility dated January 11, 2025, showed R55 had a fall on January 2, 2025, and had surgery for femur fracture on January 3, 2025. R55 was hospitalized from January 2, 2025, until January 9, 2025. R55 transferred to this facility on January 30, 2025. The transfer orders showed under advanced directives that R55 was a full code. R55's vital signs at the time of admission showed blood pressure 144/80, Pulse 62 beats per minute, Temperature 98.0 F, Respirations 18 breaths per minute and oxygen saturation was 97% on room air.

The next documentation after R55's initial admission note was January 31, 2025, at 08:04 AM written by V11 (RN) that showed R55 was found unresponsive, no pulse and cool to touch at 5:25 AM and pronounced dead by 2 nurses.

During interview of V11 (RN), on April 16, 2025, at

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S9999	Continued From page 6 2:10 PM, V11 stated she had seen R55 sleeping on his side with regular respirations during her first round at around 11:00 PM. V11 stated the next time she did rounds was between 2:30 AM and 3:00 AM, she observed R55 and appeared to be sleeping, but was making coughing type noises while breathing. V11 stated she did not assess R55 at that time. V11 stated the next time she saw R55 when she went to his room to administer medications at around 5:20 AM and attempted to wake R55 up but R55 did not respond. V11 stated she then turned on the light, did not find a pulse, found R55 was lying in brown, yellow stained sheets, did a sternal rub and left the room to call for help. V11 stated it appeared R55 had defecated, and stool was on the bed and on the floor. V11 stated she used the nurses desk phone to call the other nurses' station to get the other nurse, (V10) to help and told V13 (CNA) to go to R55's room. V11 stated she did not overhead page a code blue because she had never been taught how to overhead page. V11 then stated she called V14 (former DON) from her cell phone and went back to R55's room. V11 stated while on the cell phone with V14, V11 stated she started to do chest compressions for less than a minute, when V14, who was not in the facility, instructed her to stop compressions and not to call 911. V11 stated she did not bring the crash (emergency) cart to R55's room. V11 stated she was unsure what to do in the situation and was looking for guidance. V11 stated in hindsight she would have called 911 and started CPR as soon as she found R55 unresponsive. V11 stated she was unaware of R55's code status until she was contacting the funeral home. V11 stated as of now she does not know how to use the facility's intercom system to announce a Code Blue.	S9999		

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V14 was no longer employed by the facility and not available for interview.

On April 18, 2025, at 3:47 PM, V10 (LPN) stated she worked the overnight shift with V11 on January 31, 2025. V10 stated she was in a resident's room when she heard the desk phone ring at the nurses' station, she was unsure of the time but said it was at the end of the shift. She stated she made the resident safe and went to answer the desk phone. V10 stated V11 was calling her to come to R55's room. V10 stated by the time she got to R55's room, V11 was talking on the cell phone to V14, so she left and did not provide any assistance and did not assess R55. V10 stated when she saw V11 talking on the cell phone she left the room and went back to her assignment. V10 stated she did not call a code blue; she did not bring the crash cart and she did not call 911. When asked about who could pronounce a resident dead in the facility, V10 stated she was not sure if the facility had a policy, but only an RN can pronounce a resident dead in the facility.

On April 18, 2025, at 3:15 PM, V13 (CNA) was working on the unit with V10. V13 stated near the end of the shift, V11 asked him to help clean R55 because the family was coming. V13 stated when he walked into R55's room he did a sternal rub, but R55 did not respond. V13 stated he thought R55 might be dead, but he also thought only a doctor could pronounce someone dead. V13 stated there was no crash cart at the room, he was not aware of a code blue and the paramedics were not in the facility.

On April 16, 2025, at 5:40 PM, V12 (Medical Director) stated if a resident is found unresponsive, without a pulse and is a full code,

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the paramedics should be called. V12 stated CPR should be initiated unless rigor mortis is present. V12 stated the presence of feces on or around the resident is not an indication that CPR should not be performed.

R55's progress notes on January 31, 2025, did not indicate an assessment for signs of clinical death or the presence of rigor mortis was done and was not documented.

On April 16, 2025, at 3:05 PM, V1 (Administrator) stated there was no investigation regarding the death of R55. V1 stated he was not the Administrator at that time, both the Administrator and Director of Nursing at the time of R55's death were no longer employed by the facility.

On April 18, 2025, at 10:30 AM, V24 (Regional Director of Operations) stated the facility does not have a policy regarding nurses determining death and pronouncing time of death of a resident. V24 stated he would have to ask the Regional Clinical Consultant what the policy should be.

On April 16, 2025, at 1:00 PM, the facility provided a list of residents in the facility with their code status and there were 30 residents (R1, R5, R10, R11, R13, R15, R17, R18, R19, R20, R23, R25, R29, R33, R36, R37, R38, R39, R40, R42, R44, R45, R47, R48, R49, R52, R53, R158, R257, and R307) identified as full code status in the facility.

The Facility's policy titled "Medical Emergency Response" dated reviewed April 2025, showed "Policy Explanation and Compliance Guidelines ...1. The employee who first witnesses or is first on the sight of a medical emergency, will initiate immediate action, including CPR as appropriate

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S9999	Continued From page 9 ... 3. A Nurse will ...b. Stay with the resident ... c. Designate a staff member to announce a Code Blue, notify the physician and call 911 ...4. A Code Blue will be announced over the intercom system. 5. All available staff will respond to the emergency accordingly ...6. The staff on the unit will take the emergency cart to the code ...7. This will continue until emergency personnel arrive and resident is transported to the Emergency room via EMS (Emergency Medical Services) ...8. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and a. In accordance with the resident's advance directives." (A)	S9999		