STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055897	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET , HIGHLAND, Illinois, 62249

(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) COMPLETION DATE
S0000	Initial Comments Complaint 2548157/IL2600422	S0000		09/11/2025
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. d)Pursuant to subsection (a), general nursing care	S9999		09/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on interview and record review, the facility failed to implement a systematic approach to assess and evaluate a resident's unsafe wandering, record resident specific information, and monitor a resident with known exit seeking behaviors for 1 of 3 residents reviewed for elopement. This failure resulted in R2 eloping out of the facility on an unknown date and getting down a public street before staff were able to catch up with him and again on 8/25/2025 when R2 was seen exiting the facility unsupervised when police officers patrolling the area heard the alarm and found R2 exiting the fire door attempting to leave unsupervised and with no staff anywhere around. R3's room remains adjacent to the fire door exit. This failure has the potential to affect all 11 residents who are at risk for elopement and wandering. The elopement began on 7/19/2025, when R2 eloped from the facility through the front doors unattended. On 9/3/2025 at 10:00 AM V1, Administrator; V2, Director of Nursing (DON), and V28 Chief Operating Officer, were notified of the findings. The surveyor confirmed by observation, interview and record review, the findings were removed on 9/3/2025, but concerns remain because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Finding include: R2's Undated Face Sheet documents R2 was originally admitted to the facility on 8/16/2024 and has a diagnosis of Dementia, Anxiety Disorder, and Depression. R2's MDS dated 8/7/2025 documents R2 is severely cognitively impaired, uses a wheelchair, needs substantial/maximal assistance with sitting to standing, chair/bed to chair transfers, and a wander/elopement alarm is not used. R2's Care Plan Date Initiated 8/19/2025 documents R2 is	S9999		

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S9999	Continued from page 2 at risk for elopement due to cognitive issues and impaired safety awareness. Interventions/tasks Date Initiated 8/19/2025 documents calmly redirect and divert resident's attention, distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, and books, promptly check when alarm system goes off to ensure resident is safe and remains in facility. Interventions/Tasks Date Initiated 8/25/2025 documents 15-minute visual checks. R2's Potential Risk of Elopement dated 8/19/2024 documents R2's Risk for Elopement is resolved. R2's Elopement Risk Assessment dated 10/23/2024 at 7:35 AM documents R2 was not considered at risk for elopement. R2's Elopement Risk Assessment dated 1/10/2025 at 9:00 AM documents R2 was not considered at risk for elopement. R2's Elopement Risk Assessment dated 6/24/2025 at 5:56 AM documents R2 was not considered at risk for elopement. R2's Quarterly Nursing Evaluation Summary Note dated 8/6/2025 at 2:47 PM documents R2 is at high risk for elopement, R2 wanders within the facility or has a history of wandering, R2 verbalizes, or exhibits exit seeking behavior, and R2 has a previous history of attempted or actual elopement. R2's Elopement Evaluation dated 8/25/2025 at 8:45 PM documents R2 is a high risk for elopement, has a previous history of attempted or actual elopement, and verbalizes or exhibits exit seeking behaviors. R2's Medical Record reviewed with no clinical documentation regarding R2's elopement attempts. R2's Nursing Note dated 8/16/2024 documents R2 arrived at facility in private car accompanied by his son. R2' Son states that resident was living in a hotel locally for several months after unsuccessful integration attempts in other Long Term Care (LTC) Facilities; resident was caring for himself and became progressively weaker. Local Police Report dated 8/25/2025 at 8:31 PM documents while patrolling East on 27th Street, I heard an audible alarm coming from Highland Health Care Facility. I could see an elderly male in a wheelchair exiting a rear fire exit door and determined that this	S9999		

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S9999	Continued from page 3 was the source of the alarm. I met with R2, a resident at the facility. R2 was upset and complained that he wanted to leave the facility with police. I asked staff if R2 was a patient with Alzheimer's or Dementia or agitation. Staff indicated they did not know. I became concerned about R2 continuing to try to leave the facility unsupervised by staff and concerned about staff apparent lack of knowledge regarding the patient, his diagnoses, or needs. On 8/28/2025 at 8:05 AM R2's room location is adjacent to a fire exit door. On 8/28/2025 at 8:15 AM no binder for residents at risk for elopement noted at nurse's station. On 8/28/2025 at 8:45 AM V4, Registered Nurse (RN), stated the facility has many residents that wander. V4, RN, stated if a resident is at risk for wandering, they will have an ankle bracelet on and an alarm pad in their wheelchair. V4 stated the facility does not have a list of residents that are at risk for leaving the facility unattended. On 8/28/2025 at 8:52 AM, V5, Licensed Practical Nurse (LPN), stated if a resident is at risk for wandering, the resident will have a Wander Guard on and the facility will watch them closely. V5 stated the facility does not have a list of residents that are at risk for elopement or wandering. On 8/28/2025 at 9:20 AM V8, Certified Nursing Assistant (CNA), denied knowing of a list or book of residents that are at risk for wandering/elopement. On 8/28/2025 at 9:26 AM V9, CNA, stated residents will have a Wander Guard in place if they are at risk for exiting. V9 stated the facility does not have a list or book of residents that are at risk for wandering or eloping that she knows of. On 9/2/2025 at 12:38 PM V11, CNA, stated if a resident is at risk for wandering, the resident will have a Wander Guard in place on their wrist or ankle. V11 denied knowing if the facility keeps a list of residents who are at risk for elopement. On 9/2/2025 at 12:42 PM V13, LPN, stated the facility does not have a book or list of residents that are at risk for wandering/elopement, and residents that are at risk will have a Wander Guard in place. On 9/2/2025 at 12:48 PM V23, CNA, stated the facility does not have a list or book of residents at risk for	S9999		

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S9999	Continued from page 4 elopement that she knows of. V23 stated resident that are at risk for eloping will have a Wander Guard on and she will get told in shift report which residents at are risk. On 9/2/2025 at 12:53 PM V24, LPN, stated the facility's computer system use to have a communication page where you could tell if a resident was at risk for eloping the facility. V24 denied the facility having a list or book of resident who are at risk for eloping. On 8/29/2025 at 1:30 PM V2, Director of Nursing (DON), stated a resident's Elopement Assessment score will determine if a resident is at risk for elopement and if the need for a Wander Guard is applicable as stated in the facility's Wandering/Elopement Policy. On 9/2/2025 at 3:51PM V26, RN, stated the facility does not have a book or list of residents that are at risk for wandering or elopement. V26, RN, stated the facility just knows who is at risk and staff with watch those residents closely, and most of those residents will have a Wander Guard on. On 8/28/2025 at 11:35 AM V11, CNA, stated R2 has always walked up and down the hallways and has made the comment that he wants to go into the alleyway outside and leave the facility. V11 stated there is an exit door by R2's room that R2 will look at and say he wants to go out the door to that alley. On 8/28/2025 at 11:45 AM V12, Activity Aide, stated R2 does have exiting seeking behaviors and likes to wander. V12, stated R2 has gotten out of the facility a couple months ago and just a couple days ago. V12, stated 2 local police officers were doing their rounds in the area a couple days ago, when they heard the door alarm and found R2 and brought R2 back into the facility. On 8/28/2025 at 12:00 PM V13, LPN, stated R2 will wander in the hallways and tries to go out of the facility by the front door. On 8/28/2025 at 1:25 PM V14, LPN/MDS/Care Plan Coordinator, stated R2 does exit seek and has had a couple episodes where R2 has tried to exit the facility. V14 stated she is unsure of the exact dates R2 has tried to elope from the facility. V14 stated the facility had a recent episode where R2 tried to exit the facility and the local police department were patrolling the area, heard the door alarms, and saw R2 trying to exit the facility, but is unsure of the exact date.	S9999		

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S9999	Continued from page 5 On 8/28/2025 at 2:12 PM V15 LPN stated she was working on 8/25/2025 when she heard R2 had gone out of one of the doors of the facility and police brought R2 back inside the facility. On 8/28/2025 2:31 PM V17, CNA, stated she was working the evening on 8/25/2025 when R2 got out of the facility. V17 stated she was in another residents room providing care when she heard a nurse state over the intercom that the G Hall door was open. V17 stated she was unable to response to the door alarm due to providing resident care. V17 stated R2 does like to exit seek and by the time she was done providing care to her resident, there were local police officers in the facility that had assisted R2 to his room. V17 stated after the incident R2 was placed on 15-minute checks. On 8/28/2025 at 2:54 PM V18, CNA, stated she was in another resident's room putting a resident to bed when she heard the nurse say the G Hall door alarm was going off. V18 stated she was unable to leave the resident she was helping to check the door alarm. V18 stated R2 does wander the facility and tries to exit the facility. On 8/28/2025 at 3:03 PM V2, DON, stated if R2 gets upset, R2 will want to go outside. V2, DON, stated R2 has never exited the building without being accompanied by staff. V2, DON, stated on 8/25/2025 V3, Local Police Officer, was driving by the facility doing surveillance when V3 heard the door alarm going off and could see R2's wheelchair in the doorway. V2 stated R2 did not get out of the doorway threshold and never made it outside of the facility. V2 stated R2 did not get out of the facility, so an incident report did not need to be done. V2 stated R2 was placed on 15-minute checks on the evening of 8/25/2025 after the incident and R2 remains on 15-minute checks. On 8/28/2025 at 3:57 PM V16, RN stated she was passing medication on the front side of the building when she heard the G Hall door alarm go off. V16 stated she paged for staff to go look at the door. V16 stated when she got down the hall to the G Hall door, R2 was by the door and the local police department officers were with R2. V16 stated local police officers talked to R2, brought R2 back inside the facility and helped R2 back into his room. V16 denied knowledge of R2 previously trying to get out of the facility. On 8/29/2025 at 10:00 AM R4 stated her room is right by the G Hall exit door and R2 tries to exit the door and	S9999		

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S9999	Continued from page 6 get out of the facility. R4 stated R2 has gotten out of the facility a couple months ago and made it all the way down the road and staff have had to chase him. R4 stated R2 will tell her he wants to leave the facility. R4 stated on 8/25/2025 R2 told her that he did not want to stay in the facility and wanted to leave. R4's MDS dated 7/18/2025 documents R4 is cognitively intact. On 8/29/2025 at 10:16 AM V21, LPN, stated R2 tries to exit the facility and has exit seeking behaviors. On 8/29/2025 at 10:22 AM V3, Local Police Officer, stated he was on patrol the evening of 8/25/2025 and was in the area outside of the facility when he heard an alarm sounding. V3 stated he could see a fire exit door open and a resident trying to go outside of the door unattended. V3 stated R2 was in the process of exiting the facility and the front wheels of R2's wheelchair was already out of the doorway when he walked up to the door. V3 stated no staff was near R2 when he approached R2. V3 stated he happened to be in the right place at the right time and if he didn't hear the alarm or see R2, R2 could have gotten farther outside of the facility then he did. V3 stated he was able to speak with R2 and R2 kept saying he wanted to leave the facility. V3 stated he is unsure how R2 was able to get the door open and start leaving with no staff around him. V3 stated when he got R2 back in the facility the nurse V16 just stood there and did not assess R2 or take him back to his room. V3 stated V16 did not know any health information on R2 when V3 asked regarding R2's cognition. V3 stated when he spoke to staff regarding how R2 was able to get the facility door open, no one had any idea what was going on or could tell him any information about R2 and R2's medical diagnosis. V3 stated it seemed odd that no staff knew the cognitive status of R2 or how he was able to get the door open. On 8/29/2025 at 11:10 AM V7, Social Services Director (SSD), stated R2's cognition fluctuates and with his lack of safety awareness at time, staff needs to be present with R2 when outside. On 8/29/2025 at 11:25 AM V2 stated R2 has gone for walk down the street with staff. V2 stated she would not encourage R2 to be outside by himself. V2 stated she would expect her staff to follow the documentation policy and to document when any event or behaviors occurs. V2 stated there is no documentation regarding the event from 8/25/2025 and there was no incident report done regarding R2 trying to get out of the facility on 8/25/2025 because R2 did not make it out of the facility. V2 stated she was told by V3 that an	S9999		

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S9999	Continued from page 7 incident report would not be made, and they would consider this a wellness check. V1, Administrator, stated R2 has never gotten out of the facility and no elopement events have occurred with R2 or any resident. V1, stated she is not aware of R2 exiting the facility without staff present. V1 stated if something is not documented, then it didn't happen. On 8/29/2025 at 11:41 AM V22, RN, stated R2 is confused and thinks he needs to leave the facility. V22 stated R2 wanted to go outside previously, and she walked with him outside of the facility down the road to see the church nearby. V22, LPN, stated she is unsure the date that she walked R2 down the road by the church, but knows it was hot outside. On 9/1/2025 at 8:48 AM V19, R2's Son, stated R2 is forgetful at times and needs staff assistance with getting out of bed into his wheelchair. V19 stated he has never been informed by the facility that R2 has tried to exit the facility or has been successful with exiting the facility. On 9/2/2025 at 12:42 PM V13, LPN, stated R2 has a history of wandering the facility and trying to exit. V13 stated R2 has always been that way and will tell staff that he wants to go home. On 8/29/2025 at 1:10 PM V20, Facility Medical Director, stated R2 has a diagnosis of mental illness and dementia and does not comprehend or understand what is going on at times. V20 stated he was informed about a month ago that R2 had exited the facility out of the front lobby door and made it down the road before staff could get to him. V20 stated it is not safe for R2 to be outside unattended due to his cognition and safety awareness. V20 stated he was not informed of R2 setting off the door alarm or the police seeing R2 in the doorway trying to exit the facility on 8/25/2025. On 9/2/2025 at 1:01 PM V20, Facility Medical Director, stated he has been R2's medical doctor since R2 was admitted to the facility. V20 stated R2 has always exhibited exit seeking behaviors since admission and V20 has given the facility his opinion that R2 be on the locked unit. V20 stated it is not appropriate for R2's room to be close to any door in the facility due to his exit seeking behaviors. V20 stated if R2 was to get outside of the facility unattended, R2 could get hit by a car, get lost, fall, hit his head, and/or die. On 9/3/2025 at 10:00 AM IJ template presented and read to V1, Administrator, V2, DON, and V28, Chief Operating Officer (COO). At presentation of the IJ template, V1,	S9999		

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S9999	Continued from page 8 stated V2 had a "soft file" on the incident that happened in July while she was on vacation, which the facility called her on. V1 wanted the survey team to look at this file. Survey team stated the file would be looked at after the presentation of the IJ template. V1 and V2 were reminded they were asked for any documentation or incident reports on R2's elopement attempts or exit seeking behaviors. V1 and V2 were reminded that they stated in previous interviews that the facility did not have any documents on any elopement attempts or incidents regarding R2. On 9/3/2025 at 11:23 AM V28, COO, present this surveyor with R2's "soft file" dated 7/19/2025. The file contained 5 Staff Witness statements dated 7/19/2025 from V12, Activity Aide; V16, RN; V22, RN; V29, CNA; and V30, LPN. 4 of the 5 witness statements dated 7/19/2025 documented “signature via phone” and were not signed by the staff member. Witness statement dated 7/19/2025 by V16, RN, documents I was in another residents room, and heard door alarm. I seen R2 at the door, so I ran to him. R2 was upset because the door on the hallway was closed and was wanting to go outside. I couldn’t keep R2 inside so I went outside with him and called V22, RN. V22 then came outside and stayed with him until he was ready to come back in. We then put him on 15 minute checks. During this investigation in a previous interview on 8/28/2025 at 3:57 PM with V16, V16 denied R2 trying to exit the facility prior to the incident on 8/25/2025. The Facility’s Charting and Documentation Policy Date Revised 11/21/2020 documents “Policy Interpretation and Implementation: The following information is to be documented in the resident medical record: objective observations, treatment or services performed, changes in the resident’s condition, events, incidents, or accidents involving the resident. The Facility’s Wandering/Elopement Policy Date Revised 3/13/2024 documents “All residents are assessed for risk of unsafe wandering and/or elopement and those who are identified as at risk will be assessed for utilizing the safety interventions of a Wander Guard bracelet (where applicable) to prevent unsafe exit from the center. If not applicable, the Interdisciplinary Team will meet to discuss other safety measures that will be put in place.” Policy Interpretations and Implementations section documents “If a resident exhibits exit seeking behaviors or expresses the desire/determination to leave and if that resident is not cognitively able to support independent decision making, a new Elopement Risk Assessment and review by the interdisciplinary team will be conducted. Other	S9999		

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S9999	Continued from page 9 safety interventions may be utilized pending the assessment. (B)	S9999		

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