Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET , HILLSBORO, Illinois, 62049

(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 Annual Licensure Survey	S0000		08/21/2025
S9999	Final Observations Statement of Licensure Violations: 300.610 a)300.1210 b)300.1210 c)300.3210 t) 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. 300.1210. General Requirements for Nursing and Personal Careb) 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.c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 300.3210. Generalt) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to prevent inappropriate touching for 1 of 1 residents (R36) reviewed for abuse in the sample of 43. This failure resulted in a high likelihood of psychosocial harm due to R36's cognition making her vulnerable to abuse. Using the Reasonable Person Concept, R36 would feel humiliated and embarrassed, and would be less likely to participate in social activities and feel comfortable in social situations. Findings Include: On 7/30/25 at 12:05 PM, R36 was observed in the dining room, resident alert to self only. R36's Face Sheet, undated, documents R36 has	S9999		08/21/2025

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

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S9999	Continued from page 1 the following diagnoses: Major Depressive Disorder, Anxiety Disorder, and Dementia. R36's MDS (Minimum Data Set), dated 6/19/25, documents R36 has severe cognitive impairment. R36's Care Plan, dated 7/19/25, documents R36 has been identified as being a vulnerable person related to her diagnosis of Dementia. R36's Care Plan, dated 7/20/25, documents R36 has a potential psychosocial well-being problem related to being involved in an incident in which her personal boundaries were violated by another resident, placing her at risk for psychosocial distress and emotional harm. R 36's Progress Note, dated 7/19/25 at 9:30 AM, documents the following: "(V15, CNA, (Certified Nursing Assistant) reported that she was walking down the hall near the nurse's station when she witnessed (R75) standing by (R36) and touching her chest. (V15) immediately separated the two. (R36) was asked about the incident to which she replied about the "kids". Resident's baseline is A&Ox1 (Alert and Oriented to self). Resident assessed head to toe and no new areas/injuries noted. (V1, Administrator) was notified. Called to notify POA (Power of Attorney) with no answer, voicemail left to call the facility back. FNP (Family Nurse Practitioner) updated of the incident. Local law enforcement also notified." On 7/30/25 at 11:55 AM, R75 was observed in lobby area laying on the couch; he got up, ambulated to the dining room and then back out to the lobby. R75 is alert to self, and stated he has been at the facility for a long time, but isn't sure how long, unable to say where he is at, or give the date. R75 was unable to recall any incidents with any of the other residents. When asked, he stated he hasn't had any problems. R75's Face Sheet, undated, documents R75 has the following diagnoses: Cerebral Infarction, Dementia, Metabolic Encephalopathy, and Anxiety Disorder. R75's MDS, dated 7/2/25, documents R75 has a BIMS (Brief Interview of Mental Status) score of 00, indicating R75 has severe cognitive impairment. R75's Care Plan, dated 7/19/25, documents R75 has the potential to be spontaneous related to his Dementia diagnosis. R75's Care Plan, dated 7/20/25, documents R75 is at risk for inappropriate sexual behaviors and poses a risk for inappropriate sexual behavior during personal care related to judgement and poor boundaries. R75's Progress Note, dated 7/19/25 at 11:25 AM, documents the following: "It was reported to (V8, RN (Registered Nurse) that (R75) was witnessed with his hand under a female resident's (R36) shirt rubbing her breast. The residents were then separated. Administrator, POA, MD (Medical Doctor), and the local police department was notified. Resident placed on 1:1 (one on one observation)." R75's Progress Note, dated 7/19/25 at 2:47 PM, as a late entry, documents the following: "(V16,CNA) reported to this writer that	S9999		

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S9999	Continued from page 2 (R75) has demonstrated sexually inappropriate behaviors during showering. (V16, CNA) stated that (R75) fondles himself when female staff are providing shower assistance, makes sexually suggestive comments, and requests to be showered by specific female aides. In response to the report, this writer updated the care plan to reflect the following interventions: assign male staff to provide shower assistance when possible; schedule personal care tasks in pairs if male staff are unavailable; and instruct staff to notify the nurse immediately and document any further incidents. Resident will be monitored for continued behavioral concerns." R75's Progress Note, dated 7/23/25 at 8:00 AM, documents the following: "72-year-old male seen for an acute follow up after being notified of an incident that occurred with one of the female residents this past Saturday. Staff reported to nurse on shift that patient was witnessed touching a female resident under her shirt, rubbing her breast. It is noted that (R75) was separated away from the female resident immediately and was placed on 1 to 1 observation. On call provider, local police, and facility administrator were all notified. Additional documentation on the same day reporting that (R75) has been inappropriate with some of the female staff during showers. Behaviors of sexually suggestive comments and of him fondling himself were reported. New interventions were added to his care plan in response to the above behaviors. (R75) was visited today out in the dining room, he often is found wandering around the facility. He has a history of dementia and is forgetful and confused at his baseline. During our visit he was cooperative and pleasant." R36 and R75's Abuse Investigation, final report, dated 7/25/25, documents on 7/19/25, a staff member reported that (R75) was touching R36 in an inappropriate manner. V15, CNA, stated when she was walking down the 300 hall; R75 had his hand in R36's shirt. V15 stated she removed R75 from the situation and took R36 to the nurse. A CNA immediately started 1:1. Residents were interviewed and denied observing any inappropriate touching. Staff were interviewed and have not witnessed any resident touching another resident in an inappropriate manner. Following the investigation, the appropriate steps were followed by staff members. On 7/30/25 at 12:00 PM, V8, Registered Nurse/RN, stated R75 normally lays on the couch in the front lobby and will get up and wander around. V8 stated the CNA reported R36 was sitting at the desk, and R75 was witnessed with his hand up R36's shirt and they were separated. V8 stated she did not witness the incident, and R75 had not had any sexual behaviors prior to this incident. On 7/31/25 at 9:10 AM, V16, CNA, stated R36 is alert to her name only, and is confused. V16 stated R36 has to be watched because she	S9999		

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S9999	Continued from page 3 does take her shirt off or pull her shirt up at times. V16 stated that a couple of days before the incident with R36, she had given R75 a shower for the first time. R75 stood up during his shower; he was standing facing the wall and she was washing his legs. During this time, R75 had an erection and was fondling himself. V16 stated R75 did not make any sexual comments or gestures towards her; she thinks that because "he is a man, the shower had aroused him." V16 stated, R75 commented to her later, "maybe she could do more the next time he showered." V16 stated R75 normally will talk with another male resident or lay on the couch, and he is usually very quiet. V16 stated she is not aware of any other sexual incidents with R36 or R75. On 8/1/25 at 9:05 AM, V25, NP (Nurse Practitioner, stated she would expect the facility to prevent, report, and investigate any allegations of potential abuse. The Abuse, Prevention, and Prohibition Policy, dated 3/2025, documents this facility prohibits mistreatment, neglect, or abuse of residents. The residents must not be subjected to abuse by anyone. (B)	S9999		