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 12/05/2025

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

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S0000	Initial Comments Complaint Investigation: 25410356/2560350 2549096/2623416	S0000		12/12/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.3210t) 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. Section 300.3210 General	S9999		12/12/2025

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

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S9999	Continued from page 1 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide incontinence care for 2 of 3 Residents (R8, R9) reviewed for neglect in the sample of 3. This resulted in R8 and R9 both left saturated in urine for hours and using a reasonable person approach resulted in psychosocial harm that a person would feel ashamed, humiliated, hopeless, and neglected being left in their own incontinence of bowel/bladder. 1. R9 R9's undated face sheet documents that he was initially admitted to the facility on 10/29/2025 with diagnoses including paranoid schizophrenia and anxiety. R9's Admission Bowel and Bladder Assessment, dated 11/17/2025, documents that he has occasional incontinence episodes and requires one-person assistance with toileting. R9's Nurse's Note, dated 10/29/2025 at 7:55 PM, documents that the resident arrived from a local hospital via facility transport. He was able to answer questions appropriately, acclimated to the room, and was given a call light. No signs or symptoms of distress or injury were noted. Staff turned on the television per his request. The resident was sitting in a wheelchair in his room and requested a dinner tray, stating he was hungry. There was no documentation indicating whether R9 was incontinent of urine. A review of R9's Electronic Medical Record revealed no documentation of an Interim Care Plan upon admission dated 10/29/2025. R9's Admission Evaluation dated 10/29/2025 at 4:00 PM contains no documentation regarding bladder continence status. Toileting assistance was documented as requiring one-person assistance. A review of R9's Progress Notes dated 10/29/2025 through 11/21/2025 revealed no documentation indicating that R9 refused care related to incontinence. R9's Admission MDS, dated 11/5/2025, documents that he was alert, exhibited no rejection-of-care behaviors, and was continent of bladder. R9's Comprehensive Care Plan dated 11/21/2025 documents that he has episodes of bladder incontinence and is resistant to care. Interventions were noted on the care plan to address these issues.	S9999		

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S9999	Continued from page 2 that shift. She stated she did not recall whether she documented R9's refusal of care on 11/16/2025, nor whether she informed administration. On 11/21/2025 at 10:50 AM, R9 was observed alert, sitting in his wheelchair in the hallway. He stated he could no longer control his bladder and "p***** on himself all day long." He stated that V16, CNA, did not change him one time during the 11/20/2025 day shift, and he remained saturated with urine until night-shift CNA V11 cleaned him up and showered him. R9 stated it was humiliating to sit in p*** all day without staff assistance. He was visibly upset and stated he felt V16 had neglected him. R9 stated that V16 never offered incontinence care, and he did not refuse care from her at any time. On 11/21/2025 at 4:38 PM, V11, CNA, stated she worked the night shift on 11/20/2025 and was assigned to R9. During rounds, she noted a strong odor of urine upon entering R9's room and observed that R9 was upset. R9 told her that day-shift CNA V16 did not take care of him, and he had been soaked in urine all day. V11 stated she removed the blanket, which was saturated with urine to the point it was dripping onto the floor, and the bed was also soaked. V11 stated R9 was crying and said he was ashamed of being left in urine. V11 reported this to V15, Night Shift CNA Supervisor, who came to observe R9's condition. V11 stated she immediately provided R9 with a shower, and R9 did not refuse any care from her. On 11/21/2025 at 11:35 AM, V16, CNA, stated she worked the 11/20/2025 day shift and was assigned to R9 from 7:00 AM to 7:30 PM. She stated she entered R9's room multiple times throughout the shift and asked if he needed anything, and claimed he refused care and told her to get out of his room. V16 stated she did not report R9's alleged refusals of care and believed he was "having a bad day" and could care for himself regarding incontinence. At shift change, when she observed R9 saturated with urine alongside V11, she told V11 not to "tell on her." After leaving the facility, V16 called V3, ADON, and reported R9 refused all care that day because she "didn't want to get in trouble." V16 stated this was her first shift caring for R9, and she did not receive a report from the previous staff. She did not know he was incontinent and assumed he used a urinal. She also stated that when she told V3 about R9's alleged refusals, V3 informed her that R9 had refused care on 11/16/2025 as well. On 11/21/2025 at 12:50 PM, V3, ADON, stated V16 called her the evening of 11/20/2025 and reported that R9	S9999		

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S9999	Continued from page 3 refused care all day and that the night shift found him saturated with urine. V16 stated she did not know what to do and did not want to get in trouble for not taking care of R9. 2. R8 R8's undated face sheet documents she was initially admitted on 2/24/2023 with diagnoses including dementia and anxiety. R8's care plan, created on 6/5/2023, documents the focus: the resident has bladder incontinence. Interventions include: check every two hours and assist with toileting; provide bedpan/commode; provide pericare after each incontinence episode. R8's revised care plan, dated 5/6/2025, documents that she is resistant to care, removes soiled blankets, and throws them on the floor. Interventions include using a different caregiver, reassuring the resident if she resists ADLs, and leaving and returning later to reattempt care. R8's Quarterly MDS dated 11/3/2025 documents cognitive impairment, daily rejection-of-care behaviors, and urinary incontinence. R8's Progress Notes dated 11/20/2025 contain no documentation of care refusals or any interventions attempted to address incontinence care overnight. On 11/21/2025 at 9:38 AM, R8 was observed lying in bed with eyes open. She stated, "I am full of p***." A strong odor of urine was noted. R8 pulled down her blanket and showed the surveyor she had no clothes on, stating, "I took my diaper and gown off because it was p*** filled!" She stated lying in wet, cold p**** for hours made her feel "disgusting and extremely humiliated." Her breakfast tray was untouched. R8 asked, "Would you eat if you were cold and covered in p***?" On 11/25/2025 at 9:15 AM, V7, CNA, stated she worked the night shift and was assigned to R8 on 11/20–11/21/2025. She stated R8 is mean, combative, curses at staff, is racist, and rarely allows any hands-on care, including incontinence care. V7 recalled R8 throwing her urine-soaked gown and brief at her around 3:00 AM and refusing all care despite offers to assist her with cleaning and dressing. V7 stated she removed the soiled items from the room and placed them in the soiled utility room. On 11/21/2025 at 9:41 AM, V17, CNA, stated she was	S9999		

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S9999	Continued from page 4 assigned to R8 for the day shift. At 9:45 AM, V17 entered the room and observed V18 CNA and V19 CNA providing care to R8. R8 yelled, “Well, it’s about damn time someone came to get me out of these p*** filled sheets!” V19 assisted R8 to roll, revealing a saturated yellow-stained pad with multiple urine rings. V19 stated the pad and sheet were saturated. She provided incontinence care, changed the sheets, applied a clean brief and gown, and R8 was cooperative. V19 stated she was not assigned to R8 but assisted because R8 was saturated. She stated she did not know why R8 was without a gown or brief. On 11/21/2025 at 9:57 AM, V17 stated she arrived at 7:30 AM and conducted rounds at 7:40 AM. No report was given to her. She stated she did not wake R8 because she “did not want to disturb her,” and she was unaware of R8’s incontinence status or that she had no clothing or brief on. She stated she delivered breakfast at 9:30 AM, and R8 was still resting. V17 stated R8 is combative and yells at her frequently, so she lets her sleep when she is resting. She stated she had not provided any ADL or incontinence care that morning. On 11/21/2025 at 12:50 PM, V3, ADON, stated R8 is known to refuse care and will remove her gown and brief. V3 stated she does not know why the resident does this. On 12/5/2025 at 9:15 AM, V2, DON, stated she expects staff to check and change incontinent residents every two hours and PRN to ensure they remain clean and dry. She stated that residents have the right to refuse care; however, refusals must be reported to the charge nurse within two hours. The charge nurse must assess the resident, document refusals, document interventions attempted, and provide education on consequences (e.g., skin breakdown). Continued refusals must be reported to the provider. V2 stated she expects staff to follow all facility policies. The State Operations Manual (SOM) defines “Neglect” at §483.5 as: “the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.” B	S9999		