

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER Highland Palms Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7534 Palm Ave Highland, CA 92346	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of sexual abuse involving one of four sampled residents (Resident 1). This failure prevented the California Department of Public Health (CDPH) from ensuring the facility was taking appropriate actions to protect residents from abuse, which could jeopardize the safety and well-being of residents within the facility. Findings: A review of Resident 1's admission Record (a document containing clinical and demographic data) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (a sudden, life threatening condition where the lungs cannot provide oxygen to the blood or fail to remove carbon dioxide), diabetes mellitus (a disorder characterized by high blood sugar), and hypertension (high blood pressure). A review of Resident 1's AMA (against medical advice - document used by healthcare providers to document a resident's decision to leave a facility or discontinue treatment against medical advice.) Release Form indicated Resident 1 went home against medical advice on February 17, 2026. During a telephone interview on February 23, 2026, at 8:57 AM, with Resident 1's family member, the family member stated he took Resident 1 for an out on pass (temporary, approved leave, allowing residents to leave for family visits) on Sunday, February 15, 2026, during which she alleged that she was sexually abused by a staff in the facility. Resident 1's family member further stated that he had reported to the sheriffs and police department, and had taken Resident 1 home last Tuesday, February 17, 2026, after discharging AMA. During an interview on February 23, 2026, at 12:52 PM, with the Director of Nursing (DON), the DON stated the police came into the facility in response to Resident 1's allegations of abuse. The DON stated the facility did not initiate an investigation nor report to California Department of Public Health (CDPH) because Resident 1 had already been discharged when the facility was made aware of the alleged abuse. During a concurrent telephone interview and record review on March 9, 2026, at 9:15 AM, the DON reviewed and acknowledged the facility's policy and procedures (P&P) tilted, Abuse, Neglect, Exploitation and Misappropriation Prevention Program. The P&P indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an allegation of sexual abuse involving one of four sampled residents (Resident 1). This failure had the potential for the facility to not identify the concern or any potential harm, allowing ongoing or future abuse to continue which could jeopardize the health and safety of highly vulnerable residents living in the facility. Findings: A review of Resident 1's admission Record (a document containing clinical and demographic data) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (a sudden, life threatening condition where the lungs cannot provide oxygen to the blood or fail to remove carbon dioxide), diabetes mellitus (a disorder characterized by high blood sugar), and hypertension (high blood pressure). A review of Resident 1's AMA (against medical advice - document used by healthcare providers to document a resident's decision to leave a facility or discontinue treatment against medical advice.) Release Form indicated Resident 1 went home against medical advice on February 17, 2026. During a telephone interview on February 23, 2026, at 8:57 AM, with Resident 1's family member, the family member stated he took Resident 1 for an out on pass (temporary, approved leave, allowing residents to leave for family visits) on Sunday, February 15, 2026, during which she alleged that she was sexually abused by a staff in the facility. Resident 1's family member further stated that he had reported to the sheriffs and police department, and had taken Resident 1 home last Tuesday, February 17, 2026, after discharging AMA. During an interview on February 23, 2026, at 12:52 PM, with the Director of Nursing (DON), the DON stated the police came into the facility in response to Resident 1's allegations of abuse. The DON stated the facility did not initiate an investigation nor report to California Department of Public Health (CDPH) because Resident 1 had already been discharged when the facility was made aware of the alleged abuse. During a concurrent telephone interview and record review on March 9, 2026, at 9:15 AM, the DON reviewed and acknowledged the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program. The P&P indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.</p>		