STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: Hillsboro Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE: 1300 East Tremont Street, Hillsboro, IL 62049	

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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to prevent physical abuse from occurring for 2 of 2 residents (R2, R3) reviewed for abuse in the sample of 7. Findings include: 1.) R2's face sheet, print date of 2/19/25, documented R2 has diagnoses of Alzheimer's disease with early onset, dementia, major depressive disorder, encephalopathy, amnesia, restlessness and agitation, and personal history of traumatic brain injury. R2's MDS (Minimum Data Set), dated 12/16/24, documented R2 is severely cognitively impaired. R2's care plan, print date 2/19/25, documented R2 has the potential to become aggressive related to dementia diagnosis. R2's progress note, dated 2/8/25 at 6:21 PM, documented R2 is experiencing a change in condition. The change in condition the resident is currently experiencing is hit another resident in the common area. Writer called to the hall and informed writer that R2 had held another resident's right forearm down and hit her closed fist on the left cheek. The incident was witnessed by CNA (Certified Nurse Assistant). R3's face sheet, print date 2/19/25, documented R3 has diagnoses of intellectual disabilities, hypertension, chronic kidney disease, cataracts, and hyperlipidemia. R3's MDS, dated [DATE], documented R3 is severely cognitively impaired. R3's care plan, print date of 2/19/25, documented R3 has the potential to become aggressive related to intellectual disabilities and that R3 has been identified as a vulnerable person related to intellectual disabilities. (continued on next page)

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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Hillsboro Rehab & Hcc	1300 East Tremont Street Hillsboro, IL 62049

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's progress note, dated 2/8/25 at 6:20 PM, documented R3 is experiencing a change in condition. The change in condition the resident is currently experiencing is resident on resident, this resident was hit by another resident. Writer was called to 100 hall by CNA. CNA informed writer that resident was involved in resident on resident in the common area. Another resident held R3's right forearm down and with a closed fist, hit R3 on the left side of her face. Skin assessment done, no redness, no bruising noted. The facility's final investigation, dated 2/14/25, documented on 2/8/25 it was reported to the department that R2 and R3 were involved in an altercation. Staff observed R2 hold R3's right forearm and with a closed fist strike her left cheek. Staff immediately separated the residents. It continues, V9, CNA, reports that she was standing in 100 assisting a family member when another resident yelled (R2) just hit (R3) in the face. When I approached them to separate them, R2 was holding R3's right arm, R3 was holding the left side of her face and said, get him away from me. V9 stated, I notified the nurse to ask for assistance, redirected (R2) away from (R3), and my nurse instructed me to stay with R2 1:1 until R2 is transported to the hospital. 2.) R1's face sheet, print date of 2/19/25, documented R1 has diagnoses of chronic atrial fibrillation, congestive heart failure, diabetes, conduct disorder, dementia, brief psychotic disorder, chronic kidney disease, and hypertension. R1's MDS, dated [DATE], documented R1 is severely cognitively impaired. R1's care plan, print date of 2/19/25, documented R1 has the potential for aggression related to dementia diagnosis. R1's progress note, dated 2/11/25 at 11:46 AM, documented this resident is experiencing a change in condition. The change in condition the resident is currently experiencing is resident hit another resident on the hand and knocked him down. Resident hit another resident causing a skin tear to other resident's right hand. Resident placed on one on one immediately. R2's progress note, dated 2/11/25 at 11:32 AM, documented the resident is experiencing a change in condition. The change in condition the resident is currently experiencing is resident was hit on the hand by another resident. Nurse applied 2 steri-strips and a band-aid per NP (Nurse Practitioner) direction. The facility's initial report to IDPH (Illinois Department of Public Health), dated 2/11/25, documented R1 and R2 were involved in a resident-to-resident altercation. The residents were immediately separated and placed on increased supervision. Licensed Nurse performed a head-to-toe assessment noting a skin tear to the top of R2's hand. The MD (Medical Doctor), POA (Power of Attorney), Ombudsman, and the local police department have been notified. Witness statement, dated 2/11/25, by V5, CNA, documented at10 AM, I was assisting resident going to the bathroom. I heard a resident yell and a couple other residents yelling. I went to check, and I found (R1) on his knees leaning over (R2) saying I told you I was going to hit you, Resident told me He started stuff, so he hit him. (R1) got up and tried to pull (R2) up while dragging him. I asked the resident to let go and step away to distract him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Witness statement, dated 2/12/25, by V10, CNA, documented, around 9:50 stepped out to warm up coffee for (R1) when I came back another resident was on the floor and (R1) said 'I didn't want to have to hit him. I slapped him.' Resident had a wound to right hand when we looked over resident that he said he hit. On 2/19/25 at 12:10 PM, V5, CNA, stated she did not observe R1 hit R2 on 2/11/25, but she did observe R2 lying on the floor with R1 standing over R2. V5 stated she then observed a skin tear on R2's right hand. On 2/19/25 at 2:36 PM, V7, Regional Nurse, stated the altercations did occur between R1 and R2 and between R2 and R3. V7 stated the altercation between R1 and R2 was not witnessed, so the facility is unable to substantiate R2's skin tear was caused by R1. The facility's final investigation of the resident-to-resident abuse between R1 and R2, dated 2/20/25, documented following the investigation, based on interviews from staff, the facility is not able to determine a physical resident-to-resident altercation. Staff stated that (R2) was sitting on the floor, and it appeared that (R1) was attempting to pull him. Staff did report that (R1) was yelling I told you I was going to hit you, but this was not witnessed. (R2) did sustain a skin tear to his right hand, but based on the statements from staff the facility, cannot determine if the skin tear was a result of the fall, or an altercation between the two residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse, Prevention and Prohibition Policy, revision date of 1/24, documented, Statement of Intent: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy: This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement. Abuse Prohibition Program: The facility's abuse prohibition program includes the following seven components: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. It continues, Prevention: The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of resident property. Resident behaviors will be monitored for changes, which trigger abuse behaviors. The facility will reassess care plan interventions on a regular basis. Intervention strategies based on resident screenings will be implemented to prevent occurrences of abuse. It continues, Resident-to-Resident Altercations: When another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment and/or discharge options. Residents will be referred for behavior management when indicated. Changes in room assignments and seating arrangements will be recommended as needed. The safety of other resident and employees of the facility is of primary concerns. Not every resident-to-resident altercation result in abuse. For example, infrequent arguments or disagreements that occur during the normal social interactions would not constitute abuse. Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accident), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate ('willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. It continues, Definitions: Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.