STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Some	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** Based on interview and record review, the Facility failed to prevent physical abuse in 4 of 4 residents (R1, R4, R5, R7) reviewed for abuse in the sample of 7. This past non-compliance occurred from 1/24/26 to 2/27/26. Findings include: 1.R1's Face Sheet documents R1 was admitted to the facility on [DATE], with diagnoses including Klinefelter Syndrome and intellectual disabilities. R1's Minimum Data Set (MDS), dated [DATE], documented R1 was moderately cognitively impaired, had no behaviors, and ambulated via wheelchair. R1's Care Plan, initiated 12/1/25, documents R1 has a behavior problem related to depression. R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including bipolar disorder. R3's MDS, dated [DATE], documented R3 was cognitively intact and ambulated via wheelchair. R3's Care Plan, initiated 9/30/25, documents R3 exhibits aggression characterized by cursing, yelling, threatening, and use of inappropriate language when frustrated or triggered. R1's Progress Note, dated 2/15/26, documents R1 made an accusation that another resident hit him on the right cheek. R1's Undated Statement obtained by V2, Director of Nursing (DON), documents, I went to check on my friend and she hit me in the face and chest 3 times (pointing at center of chest). I took my tootsie rolls back from her. She go her way - I will go my way. On 3/11/26 at 9:50 AM, R1 pointed to his right cheek and chest and stated R3 hit him on the face and the chest in the dining room. He stated he did not know why she did it because he did not do anything wrong. He stated does not feel afraid of R3 but tries to stay away from her. R1's 2/15/26 Resident to Resident Physical Aggression Received documents R1 had a face injury with slight redness to right cheek. R1's 2/15/26 Skin Check documents a new issue on R1's cheek. R1's Progress Note, dated 2/15/26 at 2:40 PM, documents R1 complained of pain to right cheek, and Tylenol was provided. The Facility's Final Report sent to IDPH (Illinois Department of Public Health) on 2/17/26 documents R1 stated he was talking with R3 when she smacked him on the cheek and chest with the back of her hand. There were no witnesses. R1 stated they are friends, but he needs to stay away from her for a little while. Licensed staff assessed R1 and noted a red area on his cheek. R1 and R3 were encouraged to remain in different areas of the dining room. 2. R4's Face Sheet documents R4 was admitted to the facility on [DATE], with diagnoses including dementia and bipolar disorder. R4's Minimum Data Set (MDS), dated [DATE], documented R4 was moderately cognitively impaired and required partial assistance with bed mobility and transfer. R4's Care Plan, initiated 1/12/26, documents R4 has a behavior problem related to anxiety. R4's Progress Note, dated 2/16/26, documents R4 and another resident got into an altercation where both residents were yelling and slapping each other. R5's Face Sheet documents R5 was admitted to the facility on [DATE], with diagnoses including dementia with behavioral disturbance. R5's MDS, dated [DATE], documented R5 was severely cognitively impaired, had physical symptoms directed toward others routinely, and required supervision with mobility. R5's Care Plan, initiated 12/23/25, documents R5 has a behavior problem. R5's Progress Note, dated 2/16/26 at 5:51 PM, documents R5 was in an altercation with another resident. The Facility's Initial Report sent to IDPH on 2/16/26 documents there was a physical altercation between R4 and R5. R4's Undated Statement obtained by V1, Administrator, (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents the question, Can you tell me what happened between you and (R5)? R4's response was, Yes, we were in the dining area and she began yelling and talking bad to me. She grabbed my arm and tried to choke me. The staff stepped in and separated us. On 3/11/26 at 3:12 PM, R4 was lying in bed in her room. She stated R5 previously grabbed her around the neck and arms and was always causing problems on the unit. V7's (Certified Nursing Assistant) Written Statement, dated 2/16/26, documents, I was cleaning up dining room counter when I heard both residents arguing then I heard hitting I ran to both of them they instantly broke it up. I am unsure of who hit first. I did see both hitting at same time hands making contact to one another. On 3/11/26 at 2:54 PM, V7, Certified Nursing Assistant (CNA), stated she heard yelling, then went around the corner and saw R5 hitting R4 with her fist and R4 slapping R5. R4's SBAR Communication Form and Progress Note, dated 2/16/26, documents R4 got into an altercation with another resident where both residents were yelling and slapping each other. The Facility's Final Report sent to IDPH on 2/16/26 documents there was a physical altercation between R4 and R5 in the dining room at approximately 5:45 PM on 2/16/26. Staff reported they heard arguing and before they could reach the residents they both hit each other's hands. 3. R6's Face Sheet documents R6 was admitted to the facility on [DATE], with diagnoses including vascular dementia. R6's MDS, dated [DATE], documented R6 was severely cognitively impaired and ambulated via wheelchair. R6's Care Plan, initiated 1/19/26, documents R6 has a behavioral problem. R6's Progress Note by V15, Registered Nurse (RN), dated 1/24/26 at 7:30 PM documents V8, CNA, notified V15 of a resident to resident altercation witnessed by V8. R6 was moving down the hall in his wheelchair when his wheel became stuck on another resident's chair. Per V8, R6 was verbally aggressive toward other resident, and when he could not move his chair, he struck resident on the left arm with the back of his closed fist. On 3/12/26 at 1:05 PM, V15 was unavailable for interview. V8's Written Statement regarding 1/24/26 incident documents V8 walked out of a different resident's room and saw R5 sleeping in her wheelchair. R6's wheel was on one of R5's wheels. V8 went down to fix it when R6's closed fist punched R5's arm. On 3/11/26 at 2:36 PM, V8 stated she went to help another resident to bed and when she came out R5 and R6's wheelchairs collided. Before she could get over to help them, R6 hit R5 on her right arm with the back of his hand. The Facility's Final Report sent to IDPH on 1/28/26 documents staff exited another resident's room and observed R5 and R6's wheelchairs caught together while propelling themselves in the hall. R6 was attempting to release self, became agitated, and swung his arm, hitting R5 in the face. 4.R7's Face Sheet documents R7 was admitted to the facility on [DATE] with diagnoses including vascular dementia. R7's MDS, dated [DATE], documented R7 was severely cognitively impaired, required supervision with rolling from side to side, and required partial assistance with transfer. R7's Care Plan, dated 7/30/25, documents R7 has the potential for aggression related to dementia diagnosis. R7's Progress Note, dated 1/25/26 at 11:24 AM, documents R7 was in the hallway when another resident came up and hit her. V10, CNA, provided a written statement, dated 1/25/26, which documents she was in a resident's room and heard yelling. V10 walked into the hall and saw R5 and R7 hitting each other on the arms and chest with open hands. On 3/12/26 at 9:00 AM, V10 stated she remembers R5 and R7 slapping each other on the hands and yelling. V9, Activity Concierge, provided a written statement, dated 1/25/26, documenting V9 was in a resident room when she heard R5 and R7 yelling. She went out to the hall and saw them hitting each other on the face and chest and calling each other names. On 3/12/25 at 9:08 AM, V9 stated she remembers R5 and R7 whacking each other and had to separate them. Staff always tried to keep R5 distanced from other residents. The Facility's Final Report sent to IDPH on 1/28/26 documents staff were assisting another resident when they saw R5 and R7 slapped each other. On 3/12/26 at 1:20 PM, V1, Administrator, stated she expects the Facility to follow its abuse policy. The Facility's Abuse, Prevention and Prohibition Policy, dated 11/2025, documents 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	agencies serving the resident, family members or legal guardians, friends, or other individuals. The deficient practice that began on 1/24/26 was corrected/removed on 2/27/26 after the facility took the following actions to correct the noncompliance prior to the start of the current survey: 1-Abuse education was completed, focusing on identifying behaviors and defusing altercations before they happen. Staff will not work until education is completed. 2-Ad Hoc meeting was held with IDT (Interdisciplinary Team). The Medical Director was notified of the past-noncompliance and the plan to address. 3-The initial reports were submitted to IDPH. 4-Investigations were initiated. 5-All parties were notified of the incidents. 6-Final reports were submitted to IDPH. 7-IDT reviewed and updated care plans. 8-All residents have the potential to be affected. 9-The DON and/or designee will monitor staff understanding of abuse and how to identify behaviors and defuse altercations before they happen three times a week for 30 days. 10-Behavior tracking will be monitored during the clinical QA (Quality Assurance) meeting and if any areas of concern are identified, they will be addressed immediately. Compliance date: 2/27/26