STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145508	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health Care Center	1450 26th Street Highland, IL 62249

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to assist residents with activities of daily living for dependent residents including oral and hygiene care for 1 of 4 residents (R2) reviewed for Activities of Daily Living (ADLs) for dependent residents in the sample of 24. This failure resulted in psychosocial harm as a normal person would have been embarrassed if they could not maintain good hygiene and be clean and odor free when going out in public. Findings include: R2's Face Sheet, undated, documents R2 has the following diagnoses: Osteomyelitis, Protein Calorie Malnutrition, Non-Traumatic Extradural Hemorrhage, Aphasia, Parkinson's Disease, Stage 3 Pressure Ulcer to the Sacral Area, PVD (Peripheral Vascular Disease), Dysphagia, Seizures, Neurocognitive Disorder with Lewy Bodies, Dystonia, Hypernatremia, MDD (Major Depressive Disorder and HTN (Hypertension). R2's Minimum Data Set, dated dated [DATE], documents R2 has severe cognitive impairment, is incontinent of bowel /bladder and is dependent with Activities of Daily Living (ADLs). R2's Care Plan, dated 11/16/22, documents R2 has an ADL self-care performance deficit and requires physical assistance with daily care needs. R2's SBAR (Situation, Background, Assessment, Response), dated 6/9/24 at 4:14 PM, documents the following: blood pressure of 116/74; pulse of 78, respirations of 18, temperature of 97.8; reason for transfer: gastrostomy tube (G-Tub) blockage or dislodgement, G-tube clogged. Unable to get any nutrition or fluids to resident, refused to eat or drink by mouth. No change in mental status or functional ability. This morning upon assessment, the G-tube feeding was not connected to the resident and leaking all over the floor. Went to flush the resident with no success. Attempted to milk the tubing, pulsating fluids through, and hot coffee to de-clog it however, was not successful. Another nurse attempted to get the clog out with no success. Resident would not eat or drink anything that was offered. Sent resident to ED (Emergency Department) to get a new tube placed. MD notified at 11:20 AM; SBAR timed at 3:02 PM. R2's Progress Note, dated 6/9/24 7:57 PM, called local hospital for update on resident. Resident will be transferred to outside hospital to ICU (Intensive Care Unit) with a diagnosis of Sepsis. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER: Highland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1450 26th Street Highland, IL 62249	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	R2's ED Provider Notes, dated 6/9/24, documents the following: [AGE] year old female with a history of intracranial hemorrhage with craniotomy, seizure disorder, Parkinson's disease, dysphagia, failure to thrive and G-tube dependence presents with a reported G- tube malfunction. Upon arrival, patient is appearing severely tachycardic and hypotensive with SBP (Systolic Blood Pressure) 80's/50's. Physical exam: chronically ill with severe debility, acutely toxic appearing, neck in contracture to right, dry mucous membranes, cracked lips, tachycardic. Foley catheter inserted in LUQ (left upper quadrant) gastrostomy site. Perineal erythema and skin sloughing. Eyes closed, minimal response to noxious stimuli, spontaneous movement in all extremities, contractures to right upper and lower extremities, no verbal response. Lactic Acid - 3.3 (High) normal 0.4-2 MMOL/L; Sodium 163 (High) normal 136-145. Problems addressed: acute kidney injury, hypochloremia, severe, associated with hypovolemia, hypernatremia, severe associated with hypovolemia, septic shock, and supraventricular tachycardia resulting in worsening hypotension. Cardioversion attempted twice with adenosine and was unsuccessful. Returned to sinus tachycardia following 5mg (milligrams) of Cardizem. Disposition: transfer to another facility for ICU (Intensive Care Unit). R2's History & Physical, dated 6/9/24, documents the following: [AGE] year old female with a past medical history of traumatic subdural hematoma (March 2022) requiring a craniotomy, Parkinson's disease, bed bound, non-verbal, G-tube fed, seizures, dyslipidemia and hypothyroidism presents as a transfer from the local hospital. Patient is non-verbal at baseline and unable to supply history. History is obtained from ED and previous records. Patient resides at a nursing facility. She is G-tube fed. She had issues with the G-tube being clogged several months ago when a urinary catheter was put in place of the G-tube. She apparently never had a follow up with Gastroenterology for proper tube replacement. Today staff noted that her G-tube would not flush, so she was sent to the ED. On arrival to the ED, patient was tachypneic, tachycardic and hypotensive in the 80's. Per RN (Registered Nurse) notes, she appeared dry and disheveled on exam. She was noted to have poor dental hygiene, dry mouth, cracked lips, caked dried vaginal secretions on perineum and thighs, with a foul smell and excoriated skin that was difficult to clean. Physical exam of the skin: excoriation/erythema of the inner thigh/perineum with foul smelling drainage. Concern for elder abuse/neglect. On 6/14/2024 at 10:39 PM, V1, Administrator, stated R2 had a G-tube, it was clogged, would not flush and they sent her to the local ER. When the facility marketer spoke with the case manager at the hospital, they told us the family was concerned about R2's state and the care the facility provided. R2 was transferred from the local hospital to an outside hospital and was septic. V2, DON, spoke with the one of R2's sons on Wednesday or Thursday evening. They were mad about the catheter, which she did not have while she was here, concerns about her wound, she had an ongoing pressure ulcer on her sacrum, and they were upset and said the facility neglected her. On 6/20/24 at 3:15 PM, V10, Registered Nurse, RN, was contacted by telephone and stated R2's G-tube was clogged, and she was unable to unclog it. V10 stated R2 looked normal that morning, normally doesn't talk, is rigid. V10 stated that afternoon, she was pale and didn't look the same as she had that morning because she hadn't eaten all day. V10 stated they tried to get her to eat and drink, but she wouldn't open her mouth. V10 stated R2 did have orders for tube feeding but were unable to administer it because the tube was clogged. V10 stated she isn't sure if R2 had vaginal secretions or her pubic area/ pubic hair was matted or dry or if oral care had been completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	On 6/21/24 at 9:30 AM, V11, ED Nurse, stated R2 entered theirER on [DATE] from EMS (Emergency Medical Services) at 3:13 PM. V11 stated R2 was normally non-verbal. V11 stated R2's head was turned to the right side, her lips were dry and cracked, there was a film coating her teeth, her tongue had a scab on it and was cracked. V11 stated R2's vital signs upon arrival were 85/64 (blood pressure); 100.6 (temperature); 32 (respirations), 119 (heart rate), 62.2 kilograms (136.8 pounds). V11 stated she went to insert an indwelling urinary catheter and R2's pubic hair was adhered to her labia from vaginal secretions, and she had sloughing on the inner groin area from her diaper. V11 stated she had to clean her perineal area before she could even try and insert the catheter. V11 stated once the catheter was inserted, she only had 20cc (cubic centimeters) of return urine after having a fluid bolus IV (intravenously). V11 stated R2 had a very strong odor in her mouth and perineal area. V11 stated she was told by the nursing facility that R2's G-tube was clogged, and she hadn't had any nutrition since the night before and nothing was done about it until the day shift came in. V11 stated she was very concerned with R2's lack of hydration and that R2 hadn't received basic care at the facility when she was sent to the ED on 6/9/24. On 6/27/24 at 9:10 AM, V38, R2's Son, stated R2 would have been embarrassed and would not have gone out to the hospital or in public without being clean, dry, teeth brushed and without odors. V38 stated R2 was a nurse and spent her life caring for others and would have wanted to be cared for in the same way she cared for them. V38 stated R2 has Parkinson's Disease, is unable to speak, her hands are curled up, she must be fed and needs complete care. The Perineal Care Procedure, undated, documents the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritations and to observe the resident's skin condition. The Oral Care Policy, with a review date of 4/6/23, documents the purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to provide timely care/treatment for 1 of 4 residents (R2) reviewed for quality of care in the sample of 24. Findings include: R2's Face Sheet, undated, documents R2 has the following diagnoses: Osteomyelitis, Protein Calorie Malnutrition, Non-Traumatic Extradural Hemorrhage, Aphasia, Parkinson's Disease, Stage 3 Pressure Ulcer to the Sacral Area, PVD (Peripheral Vascular Disease), Dysphagia, Seizures, Neurocognitive Disorder with Lewy Bodies, Dystonia, Hypernatremia, MDD (Major Depressive Disorder and HTN (Hypertension). R2's Minimum Data Set, (MDS), dated [DATE], documents R2 has severe cognitive impairment is dependent upon staff for ADLs (Activities of Daily Living), has coughing with thin liquids, loss of liquids/solids from mouth when eating/drinking, choking/coughing when eating, swallowing medications, and receives 51/% or more of total calories through tube feeding; receives 501cc/day or more of fluids by tube feeding. R2's Care Plan, dated 11/16/22, documents R2 has an ADL self-care performance deficit, requires physical assistance with daily care needs, has the potential for fluid deficit and requires a tube feeding due to dysphagia. R2's SBAR (Situation, Background, Assessment, Response), dated 6/9/24 at 4:14 PM, documents the following: blood pressure of 116/74; pulse of 78, respirations of 18, temperature of 97.8 (degrees Fahrenheit); reason for transfer: gastrostomy tube (G-Tub) blockage or dislodgement, G-tube clogged. Unable to get any nutrition or fluids to resident, refused to eat or drink by mouth. No change in mental status or functional ability. This morning upon assessment, the G-tube feeding was not connected to the resident and leaking all over the floor. Went to flush the resident with no success. Attempted to milk the tubing, pulsating fluids through, and hot coffee to de-clog it, however, was not successful. Another nurse attempted to get the clog out with no success. Resident would not eat or drink anything that was offered. Sent resident to ED (Emergency Department) to get a new tube placed. MD notified at 11:20 AM with a recommendation from the primary clinician to send to the ED. The SBAR had no documentation on the time that R2 was sent to the ED as recommended by the physician. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's ED Provider Notes, dated 6/9/24, documents the following: [AGE] year old female with a history of intracranial hemorrhage with craniotomy, seizure disorder, Parkinson's disease, dysphagia, failure to thrive and G-tube dependence presents with a reported G- tube malfunction. Per report, the patient is completely G- tube dependent. She was seen in this ED previously after G-tube dislodgment in 1/2024. At that time, a replacement G-tube was unable to be placed but a urinary catheter was inserted in place of the G-tube for continuation of feeds. Instructions were provided to follow-up with the patient's Gastroenterologist, V13, who placed the initial G-tube, however, this follow-up was never completed. She was sent to the ED today after staff was unable to flush the tube. Upon arrival, patient is appearing severely tachycardic and hypotensive with SBP (Systolic Blood Pressure) 80's/50's. Physical exam: chronically ill with severe debility, acutely toxic appearing, neck in contracture to right, dry mucous membranes, cracked lips, tachycardic. Foley catheter inserted in LUQ (left upper quadrant) gastrostomy site. Perineal erythema and skin sloughing. Eyes closed, minimal response to noxious stimuli, spontaneous movement in all extremities, contractures to right upper and lower extremities, no verbal response. Lactic Acid - 3.3 (High) normal 0.4-2 MMOL/L; Sodium 163 (High) normal 136-145. Problems addressed: acute kidney injury, hypochloremia, severe, associated with hypovolemia, hypernatremia, severe associated with hypovolemia, septic shock, and supraventricular tachycardia resulting in worsening hypotension. Cardioversion attempted twice with adenosine and was unsuccessful. Returned to sinus tachycardia following 5mg (milligrams) of Cardizem. Disposition: transfer to another facility for ICU (Intensive Care Unit). The care timeline documents R2 arrived at the ED at 3:13 PM. The care timeline documents R2 did not arrive at the ED until 3 hours and 53 minutes following the recommendation by the primary clinician that was documented on R2's SBAR dated 6/9/24. On 6/20/24 at 3:15 PM, V10, Registered Nurse, RN, was contacted by telephone and stated R2's G-tube was clogged, and she was unable to unclog it. V10 stated R2 looked normal that morning, normally doesn't talk, is rigid. V10 stated that afternoon, she was pale and didn't look the same as she had that morning because she hadn't eaten all day. V10 stated they tried to get her to eat and drink, but she wouldn't open her mouth. V10 stated R2 did have orders for tube feeding but were unable to administer it because the tube was clogged. On 6/21/24 at 9:30 AM, V11, ED Nurse, stated R2 entered theirER on [DATE] from EMS at 3:13 PM. V11 stated she was told by the nursing facility that R2's G-tube was clogged, and she hadn't had any nutrition since the night before and nothing was done about it until the day shift came in. V11 stated she was very concerned with R2's lack of hydration and that R2 hadn't received basic care at the facility when she was sent to the ED on 6/9/24. V11 stated in her medical opinion, there was a delay in treatment which affected R2's plan of care. On 6/21/24 at 12:05 PM, V22, RN, stated R2 had a urinary catheter that was being used in place of her G-tube and was put in by the hospital months ago. V22 stated it clogged often with the tube feeding and water flushes. V22 stated they were also giving R2's medications through the G-tube. V22 stated she isn't sure if there was a plan to replace the urinary catheter with an actual G-tube. V22 stated R2 was able to eat food and drink fluids. V22 stated R2's appetite varied, she would eat 25-50% of meals. V22 stated she wasn't here when R2 was sent to the hospital but was told it was due to her tube being clogged and they were unable to unclog it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Acute Change of Condition Policy, with a revision date of 1/23/23, documents this facility shall identify and treat residents with acute changes of conditions. The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. The physician will help identify and authorize appropriate treatments. If it is decided, after sufficient review, that care or observation cannot reasonably be provided at the facility, the physician will authorize a transfer to an acute hospital, emergency room or another appropriate setting.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to provide gastrostomy tube care per standards of practice for 1 of 4 residents (R2) reviewed for tube feeding management in the sample of 24. Findings include: R2's Face Sheet, undated, documents R2 has the following diagnoses: Osteomyelitis, Protein Calorie Malnutrition, Non-Traumatic Extradural Hemorrhage, Aphasia, Parkinson's Disease, Stage 3 Pressure Ulcer to the Sacral Area, PVD (Peripheral Vascular Disease), Dysphagia, Seizures, Neurocognitive Disorder with Lewy Bodies, Dystonia, Hypernatremia, MDD (Major Depressive Disorder and HTN (Hypertension). R2's Minimum Data Set, MDS, 6/9/24, documents R2 has severe cognitive impairment is dependent upon staff for ADLs (Activities of Daily Living), has coughing with thin liquids, loss of liquids/solids from mouth when eating/drinking, choking/coughing when eating, swallowing medications, and receives 51/% or more of total calories through tube feeding; receives 501cc/day or more of fluids by tube feeding. R2's Care Plan, dated 11/16/22, documents R2 has an ADL self-care performance deficit, requires physical assistance with daily care needs, has the potential for fluid deficit and requires a tube feeding due to dysphagia. R2's Physician Order Sheet, POS, documents an order dated 1/10/24, to refer to V13, R2's Gastroenterologist, related to G-tube (gastrostomy tube) replacement. R2's Progress Note, dated 1/10/2024 at 12:51 PM, document the following: orders placed for a Gastroenterology referral with V13, R2's Gastroenterologist, related to replacing the G-tube. (V39, Certified Nursing Assistant, CNA), notified of orders for referral, waiting for MD (medical doctor) signature to set up appointment. There was no further documentation in R2's progress notes that the referral/appointment was made with V13. R2's Progress Note, dated 1/14/2024 at 9:30 AM documents the following: R2 was transferred to the local hospital for G-tube displacement. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's SBAR (Situation, Background, Assessment, Response), dated 6/9/24 at 4:14 PM, documents the following: blood pressure of 116/74; pulse of 78, respirations of 18, temperature of 97.8; reason for transfer: gastrostomy tube (G-Tube) blockage or dislodgement, G-tube clogged. Unable to get any nutrition or fluids to resident, refused to eat or drink by mouth. No change in mental status or functional ability. This morning upon assessment, the G-tube feeding was not connected to the resident and leaking all over the floor. Went to flush the resident with no success. Attempted to milk the tubing, pulsating fluids through, and hot coffee to de-clog it, however, was not successful. Another nurse attempted to get the clog out with no success. Resident would not eat or drink anything that was offered. Sent resident to ED (Emergency Department) to get a new tube placed. MD notified at 11:20 AM with a recommendation from the primary clinician to send to the ED. R2's ED Provider Notes, dated 6/9/24, documents the following: [AGE] year old female with a history of intracranial hemorrhage with craniotomy, seizure disorder, Parkinson's disease, dysphagia, failure to thrive and G-tube dependence presents with a reported G- tube malfunction. Per report, the patient is completely G- tube dependent. She was seen in this ED previously after G-tube dislodgment in 1/2024. At that time, a replacement G-tube was unable to be placed but a urinary catheter was inserted in place of the G-tube for continuation of feeds. Instructions were provided to follow-up with the patient's Gastroenterologist, V13, who placed the initial G-tube, however, this follow-up was never completed. She was sent to the ED today after staff was unable to flush the tube. Upon arrival, patient is appearing severely tachycardic and hypotensive with SBP (Systolic Blood Pressure) 80's/50's. Physical exam: chronically ill with severe debility, acutely toxic appearing, neck in contracture to right, dry mucous membranes, cracked lips, tachycardic. Foley catheter inserted in LUQ (left upper quadrant) gastrostomy site. Perineal erythema and skin sloughing. Eyes closed, minimal response to noxious stimuli, spontaneous movement in all extremities, contractures to right upper and lower extremities, no verbal response. Lactic Acid - 3.3 (High) normal 0.4-2 MMOL/L; Sodium 163 (High) normal 136-145. Problems addressed: acute kidney injury, hypochloremia, severe, associated with hypovolemia, hypernatremia, severe associated with hypovolemia, septic shock, and supraventricular tachycardia resulting in worsening hypotension. Cardioversion attempted twice with adenosine and was unsuccessful. Returned to sinus tachycardia following 5mg (milligrams) of Cardizem. Disposition: transfer to another facility for ICU (Intensive Care Unit). The care timeline documents R2 arrived at the ED at 3:13 PM. The care timeline documents R2 did not arrive at the ED until 3 hours and 53 minutes following the recommendation by the primary clinician that was documented on R2's SBAR dated 6/9/24. R2's History & Physical, dated 6/9/24, documents the following: [AGE] year old female with a past medical history of traumatic subdural hematoma (March 2022) requiring a craniotomy, Parkinson's disease, bed bound, non-verbal, G-tube fed, seizures, dyslipidemia and hypothyroidism presents as a transfer from the local hospital. Patient is non-verbal at baseline and unable to supply history. History is obtained from ED and previous records. Patient resides at a nursing facility. She is G-tube fed. She had issues with the G-tube being clogged several months ago when a urinary catheter was put in place of the G-tube. She apparently never had a follow up with Gastroenterology for proper tube replacement. Today staff noted that her G-tube would not flush, so she was sent to the ED. On 6/14/2024 at 10:39 PM, V1, Administrator, stated R2 had a G-tube, it was clogged, would not flush and they sent her to the local ER. When the facility marketer spoke with the case manager at the hospital, they told us the family was concerned about R2's state and the care the facility provided. R2 was transferred from the local hospital to an outside hospital and was septic. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 3:15 PM, V10, Registered Nurse, RN, was contacted by telephone and stated R2's G-tube was clogged, and she was unable to unclog it. V10 stated R2 looked normal that morning, normally doesn't talk, is rigid. V10 stated that afternoon, she was pale and didn't look the same as she had that morning because she hadn't eaten all day. V10 stated they tried to get her to eat and drink, but she wouldn't open her mouth. V10 stated R2 did have orders for tube feeding but were unable to administer it because the tube was clogged. V10 stated she isn't sure if R2 had vaginal secretions or her pubic area/ pubic hair was matted or dry or if oral care had been completed. On 6/21/24 at 9:30 AM, V11, ED Nurse, stated R2 entered theirER on [DATE] from EMS at 3:13 PM. V11 stated R2 was normally non-verbal. V11 stated she was told by the nursing facility that R2's G-tube was clogged, and she hadn't had any nutrition since the night before and nothing was done about it until the day shift came in. V11 stated she was very concerned with R2's lack of hydration and that R2 hadn't received basic care at the facility when she was sent to the ED on 6/9/24. V11 stated she was told by the facility that R2's G-tube was clogged, and she hadn't had any nutrition since the night before and nothing was done about it until the day shift came in. V11 stated R2 had been seen in their ER in January 2024 for a dislodged G-tube, they weren't able to replace it, so she was transferred to an outside hospital for replacement. V11 stated at the outside hospital, either because they couldn't replace it or didn't have the correct supplies to replace it, a urinary catheter was inserted in place of the G-tube so R2 could continue to receive her feedings. V11 stated R2 was supposed to follow up with V13, R2's Gastroenterologist and never did. V11 stated she was very concerned with R2's lack of hydration and that R2 hadn't received basic care at the facility when she was sent to theirER on [DATE]. V11 stated R2 had an acute kidney injury and was in kidney failure due to having no hydration for over 24 hours. V11 stated in her medical opinion, there was a delay in treatment which affected R2's plan of care. On 6/21/24 at 10:57 AM, V18, V13's Nurse Manager, stated V13 was not able to speak with the surveyor at this time but she discussed R2 with him and he stated he doesn't remember being consulted on R2 in January, he would have seen her and taken her to the operating room to replace the G-tube. V18 stated she saw in January 2024 on R2's after visit summary, where the hospital ordered R2 to follow up with V13 ASAP (as soon as possible) for G-tube replacement. V18 stated they have gone through their records and there have not been any telephone encounters for an appointment request for R2 in 2024. V18 stated V13 would not have recommended a urinary catheter be used as a G-tube any longer than a few days maybe a couple of weeks until a G-tube could be replaced, not 5 months as in R2's case. On 6/21/24 at 11:15 AM, V2, Director of Nursing, stated she does not see where the follow-up appointment with V13 was scheduled for R2. On 6/21/24 at 12:05 PM, V22, Registered Nurse, RN, stated R2 had a urinary catheter that was being used in place of her G-tube and was put in by the hospital months ago. V22 stated it clogged often with the tube feeding and water flushes. V22 stated they were also giving R2's medications through the G-tube. V22 stated she isn't sure if there was a plan to replace the urinary catheter with an actual G-tube. V22 stated R2 was able to eat food and drink fluids. V22 stated R2's appetite varied, she would eat 25-50% of meals. V22 stated she wasn't here when R2 was sent to the hospital but was told it was due to her tube being clogged and they were unable to unclog it. On 6/21/24 at 12:10 PM, V23, CNA Coordinator, stated R2 needed complete care, was non-verbal and unable to tell them what she needed. V23 stated R2 was able to eat and drink by mouth, was fed usually between 25-50% and drank fluids through a straw. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health Care Center	1450 26th Street Highland, IL 62249

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/24 at 12:15 PM, V4, RN, stated the night of 6/8/24, she worked the midnight shift into 6/9/24. Stated R2 had a Foley catheter that was being used as a G-tube and it had gotten clogged at the beginning of her shift, and she was able to unclog it and it was working. Stated R2 received her tube feeding all night and didn't have any further problems with it. Stated R2 had water flushes that were programmed into the feeding pump that gave her flushes, the nurses would also give her 60cc water flushes twice during the night. V4 stated R2 was sent back from the hospital months ago with a urinary catheter being used in place of a G-tube and she isn't sure why. V4 stated recently, unable to give exact time frame, R2's tube began to clog frequently, and it needed replaced. V4 stated they would have to milk it and flush it often to keep it from clogging up. On 6/21/24 at 12:25 PM, V24, Licensed Practical Nurse, LPN, stated she worked the weekend before R2 was sent to the hospital and she didn't see any changes in R2's condition. V24 stated R2 was receiving tube feeding continuously and water flushes were administered via the feeding pump plus they were giving a 60cc water flush twice a shift to keep it from clogging up. On 6/21/24 at 2:10 PM, V8, MDS/LPN, stated R2 was receiving tube feeding and was dependent on staff for all care. On 6/27/24 at 9:10 AM, V38, R2's Son, stated R2 has Parkinson's Disease, is unable to speak, her hands are curled up, she must be fed and needs complete care. V38 stated when R2 went to the hospital in January 2024, V13, R2's Gastroenterologist was on vacation so he couldn't be consulted while R2 was in the ER. V38 stated the facility called him to get the contact information for V13, which he provided. V38 stated he was not aware that a urinary catheter was placed as a temporary gastrostomy tube until V13 could replace R2's gastrostomy/feeding tube. V38 stated R2 was sent to the hospital recently due to problems with her feeding tube. V38 stated R2 was able to take food and fluids by mouth but he doesn't know if the facility was doing that because she was dehydrated and had a blood infection when she went to the hospital.