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	09/04/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a systematic approach to assess and evaluate a resident's unsafe wandering, record resident specific information, and monitor a resident with known exit seeking behaviors for 1 of 3 residents reviewed for elopement. This failure resulted in R2 eloping out of the facility on an unknown date and getting down a public street before staff were able to catch up with him and again on 8/25/2025 when R2 was seen exiting the facility unsupervised when police officers patrolling the area heard the alarm and found R2 exiting the fire door attempting to leave unsupervised and with no staff anywhere around. R3's room remains adjacent to the fire door exit. This failure has the potential to affect all 11 residents who are at risk for elopement and wandering.The Immediate Jeopardy began on 7/19/2025, when R2 eloped from the facility through the front doors unattended. On 9/3/2025 at 10:00 AM V1, Administrator; V2, Director of Nursing (DON), and V28 Chief Operating Officer, were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on 9/3/2025, but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Finding include:R2's Undated Face Sheet documents R2 was originally admitted to the facility on [DATE] and has a diagnosis of Dementia, Anxiety Disorder, and Depression.R2's MDS dated [DATE] documents R2 is severely cognitively impaired, uses a wheelchair, needs substantial/maximal assistance with sitting to standing, chair/bed to chair transfers, and a wander/elopement alarm is not used.R2's Care Plan Date Initiated 8/19/2025 documents R2 is at risk for elopement due to cognitive issues and impaired safety awareness. Interventions/tasks Date Initiated 8/19/2025 documents calmly redirect and divert resident's attention, distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, and books, promptly check when alarm system goes off to ensure resident is safe and remains in facility. Interventions/Tasks Date Initiated 8/25/2025 documents 15-minute visual checks.R2's Potential Risk of Elopement dated 8/19/2024 documents R2's Risk for Elopement is resolved.R2's Elopement Risk assessment dated [DATE] at 7:35 AM documents R2 was not considered at risk for elopement.R2's Elopement Risk assessment dated [DATE] at 9:00 AM documents R2 was not considered at risk for elopement.R2's Elopement Risk assessment dated [DATE] at 5:56 AM documents R2 was not considered at risk for elopement.R2's Quarterly Nursing Evaluation Summary Note dated 8/6/2025 at 2:47 PM documents R2 is at high risk for elopement, R2 wanders within the facility or has a history of wandering, R2 verbalizes, or exhibits exit seeking behavior, and R2 has a previous history of attempted or actual elopement.R2's Elopement Evaluation dated 8/25/2025 at 8:45 PM documents R2 is a high risk for elopement, has a previous history of attempted or actual elopement, and verbalizes or exhibits exit seeking behaviors. R2's Medical Record reviewed with no clinical documentation regarding R2's elopement attempts. R2's Nursing Note dated 8/16/2024 documents R2 arrived at facility in private car accompanied by his son. R2' Son states that resident was living in a hotel locally for several months after unsuccessful integration attempts in other Long Term Care (LTC) Facilities; resident was caring for himself and became progressively weaker.Local Police Report dated 8/25/2025 at 8:31 PM documents while patrolling East on 27th Street, I heard an audible alarm coming from [NAME] Health Care Facility. I could see an elderly male in a wheelchair exiting a rear fire exit door and determined that this was the source of the alarm. I met with R2, a resident at the facility. R2 was upset and complained that he wanted to leave the facility with police. I asked staff if R2 was a patient with Alzheimer's or Dementia or agitation. Staff indicated they did not know. I became concerned about R2 continuing to try to leave the facility unsupervised by staff and concerned about staff apparent lack of knowledge regarding the patient, his diagnoses, or needs.On 8/28/2025 at 8:05 AM R2's room location is adjacent to a fire exit door.On 8/28/2025 at 8:15 AM no binder for residents at risk for elopement noted at nurse's station. On 8/28/2025 at 8:45 AM V4, Registered Nurse (RN), stated the facility has many residents that wander. V4, RN, stated if a resident is at risk for wandering, they will have an ankle bracelet on and an alarm pad in their wheelchair. V4 stated the facility does not have a list of residents that are at risk for leaving the facility unattended.On 8/28/2025 at 8:52 AM, V5, Licensed Practical Nurse (LPN), stated if a resident is at risk for wandering, the resident will have a Wander Guard on and the facility will watch them closely. V5 stated the facility does not have a list of residents that are at risk for elopement or wandering.On 8/28/2025 at 9:20 AM V8, Certified Nursing Assistant (CNA), denied knowing of a list or book