

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 12/05/2025
NAME OF PROVIDER OR SUPPLIER Highland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide incontinence care for 2 of 3 Residents (R8, R9) reviewed for neglect in the sample of 3. This resulted in R8 and R9 both left saturated in urine for hours and using a reasonable person approach resulted in psychosocial harm that a person would feel ashamed, humiliated, hopeless, and neglected being left in their own incontinence of bowel/bladder. Findings include:</p> <p>1. R9</p> <p>R9's undated face sheet documents that he was initially admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and anxiety.</p> <p>R9's admission Bowel and Bladder Assessment, dated 11/17/2025, documents that he has occasional incontinence episodes and requires one-person assistance with toileting.</p> <p>R9's Nurse's Note, dated 10/29/2025 at 7:55 PM, documents that the resident arrived from a local hospital via facility transport. He was able to answer questions appropriately, acclimated to the room, and was given a call light. No signs or symptoms of distress or injury were noted. Staff turned on the television per his request. The resident was sitting in a wheelchair in his room and requested a dinner tray, stating he was hungry. There was no documentation indicating whether R9 was incontinent of urine.</p> <p>A review of R9's Electronic Medical Record revealed no documentation of an Interim Care Plan upon admission dated 10/29/2025.</p> <p>R9's admission Evaluation dated 10/29/2025 at 4:00 PM contains no documentation regarding bladder continence status. Toileting assistance was documented as requiring one-person assistance.</p> <p>A review of R9's Progress Notes dated 10/29/2025 through 11/21/2025 revealed no documentation indicating that R9 refused care related to incontinence.</p> <p>R9's admission MDS, dated [DATE], documents that he was alert, exhibited no rejection-of-care behaviors, and was continent of bladder.</p> <p>R9's Comprehensive Care Plan dated 11/21/2025 documents that he has episodes of bladder incontinence and is resistant to care. Interventions were noted on the care plan to address these issues.</p> <p>(continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/2025 at 12:50 PM, V3 (ADON) stated she worked the floor as a CNA on 11/16/2025 and was assigned to R9. V3 recalled that R9 refused care from her during that shift. She stated she did not recall whether she documented R9's refusal of care on 11/16/2025, nor whether she informed administration.</p> <p>On 11/21/2025 at 10:50 AM, R9 was observed alert, sitting in his wheelchair in the hallway. He stated he could no longer control his bladder and p***** on himself all day long. He stated that V16, CNA, did not change him one time during the 11/20/2025 day shift, and he remained saturated with urine until night-shift CNA V11 cleaned him up and showered him. R9 stated it was humiliating to sit in p*** all day without staff assistance. He was visibly upset and stated he felt V16 had neglected him. R9 stated that V16 never offered incontinence care, and he did not refuse care from her at any time.</p> <p>On 11/21/2025 at 4:38 PM, V11, CNA, stated she worked the night shift on 11/20/2025 and was assigned to R9. During rounds, she noted a strong odor of urine upon entering R9's room and observed that R9 was upset. R9 told her that day-shift CNA V16 did not take care of him, and he had been soaked in urine all day. V11 stated she removed the blanket, which was saturated with urine to the point it was dripping onto the floor, and the bed was also soaked. V11 stated R9 was crying and said he was ashamed of being left in urine. V11 reported this to V15, Night Shift CNA Supervisor, who came to observe R9's condition. V11 stated she immediately provided R9 with a shower, and R9 did not refuse any care from her.</p> <p>On 11/21/2025 at 11:35 AM, V16, CNA, stated she worked the 11/20/2025 day shift and was assigned to R9 from 7:00 AM to 7:30 PM. She stated she entered R9's room multiple times throughout the shift and asked if he needed anything, and claimed he refused care and told her to get out of his room. V16 stated she did not report R9's alleged refusals of care and believed he was having a bad day and could care for himself regarding incontinence. At shift change, when she observed R9 saturated with urine alongside V11, she told V11 not to tell on her. After leaving the facility, V16 called V3, ADON, and reported R9 refused all care that day because she didn't want to get in trouble. V16 stated this was her first shift caring for R9, and she did not receive a report from the previous staff. She did not know he was incontinent and assumed he used a urinal. She also stated that when she told V3 about R9's alleged refusals, V3 informed her that R9 had refused care on 11/16/2025 as well.</p> <p>On 11/21/2025 at 12:50 PM, V3, ADON, stated V16 called her the evening of 11/20/2025 and reported that R9 refused care all day and that the night shift found him saturated with urine. V16 stated she did not know what to do and did not want to get in trouble for not taking care of R9.</p> <p>2. R8</p> <p>R8's undated face sheet documents she was initially admitted on [DATE] with diagnoses including dementia and anxiety.</p> <p>R8's care plan, created on 6/5/2023, documents the focus: the resident has bladder incontinence. Interventions include: check every two hours and assist with toileting; provide bedpan/commode; provide pericare after each incontinence episode. R8's revised care plan, dated 5/6/2025, documents that she is resistant to care, removes soiled blankets, and throws them on the floor. Interventions include using a different caregiver, reassuring the resident if she resists ADLs, and leaving and returning later to reattempt care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R8's Quarterly MDS dated [DATE] documents cognitive impairment, daily rejection-of-care behaviors, and urinary incontinence.</p> <p>R8's Progress Notes dated 11/20/2025 contain no documentation of care refusals or any interventions attempted to address incontinence care overnight.</p> <p>On 11/21/2025 at 9:38 AM, R8 was observed lying in bed with eyes open. She stated, I am full of p***. A strong odor of urine was noted. R8 pulled down her blanket and showed the surveyor she had no clothes on, stating, I took my diaper and gown off because it was p*** filled! She stated lying in wet, cold p**** for hours made her feel disgusting and extremely humiliated. Her breakfast tray was untouched. R8 asked, Would you eat if you were cold and covered in p***?</p> <p>On 11/25/2025 at 9:15 AM, V7, CNA, stated she worked the night shift and was assigned to R8 on 11/20&ndash;11/21/2025. She stated R8 is mean, combative, curses at staff, is racist, and rarely allows any hands-on care, including incontinence care. V7 recalled R8 throwing her urine-soaked gown and brief at her around 3:00 AM and refusing all care despite offers to assist her with cleaning and dressing. V7 stated she removed the soiled items from the room and placed them in the soiled utility room.</p> <p>On 11/21/2025 at 9:41 AM, V17, CNA, stated she was assigned to R8 for the day shift.</p> <p>At 9:45 AM, V17 entered the room and observed V18 CNA and V19 CNA providing care to R8. R8 yelled, Well, it's about damn time someone came to get me out of these p*** filled sheets! V19 assisted R8 to roll, revealing a saturated yellow-stained pad with multiple urine rings. V19 stated the pad and sheet were saturated. She provided incontinence care, changed the sheets, applied a clean brief and gown, and R8 was cooperative. V19 stated she was not assigned to R8 but assisted because R8 was saturated. She stated she did not know why R8 was without a gown or brief.</p> <p>On 11/21/2025 at 9:57 AM, V17 stated she arrived at 7:30 AM and conducted rounds at 7:40 AM. No report was given to her. She stated she did not wake R8 because she did not want to disturb her, and she was unaware of R8's incontinence status or that she had no clothing or brief on. She stated she delivered breakfast at 9:30 AM, and R8 was still resting. V17 stated R8 is combative and yells at her frequently, so she lets her sleep when she is resting. She stated she had not provided any ADL or incontinence care that morning.</p> <p>On 11/21/2025 at 12:50 PM, V3, ADON, stated R8 is known to refuse care and will remove her gown and brief. V3 stated she does not know why the resident does this.</p> <p>On 12/5/2025 at 9:15 AM, V2, DON, stated she expects staff to check and change incontinent residents every two hours and PRN to ensure they remain clean and dry. She stated that residents have the right to refuse care; however, refusals must be reported to the charge nurse within two hours. The charge nurse must assess the resident, document refusals, document interventions attempted, and provide education on consequences (e.g., skin breakdown). Continued refusals must be reported to the provider. V2 stated she expects staff to follow all facility policies.</p> <p>The State Operations Manual (SOM) defines Neglect at 483.5 as: the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 2 (R8, R9) of 3 residents received adequate and timely incontinence care for ADL dependent residents reviewed for incontinence in the sample of 3. Findings include: 1. R9's Undated Face Sheet documents R9 was initially admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and anxiety. R9's admission Bowel and Bladder assessment dated [DATE], documents R9 has occasional incontinence episodes and needs one assist with his toileting needs. R9's Nurse's Note, dated 10/29/2025 at 7:55 PM, documents resident arrived from local hospital via facility transport. Resident able to answer questions appropriately. Resident acclimated to room and given call light. No s/s (side or symptoms) of distress or injury. TV turned on per resident's request. Resident sitting in wheelchair in room, requested dinner tray as resident states he is hungry. No documentation if resident is incontinent of urine. R9's Electronic Medical Record no documentation of an Interim Care Plan upon admission dated 10/29/2025. R9's admission MDS dated [DATE] documents he was alert, no rejection of care behaviors, continent of bladder. R9's Comprehensive Care Plan dated 11/21/2025 documents R9 has episodes of bladder incontinence and is resistive to care. Staff documented interventions on the care plan to address these issues. On 11/21/2025 at 10:50 AM R9 alert, up in wheelchair in hallway stated he can't control his bladder anymore so he p***** on himself all day long and V16, CNA (Certified Nurse Aide) didn't change him one time yesterday (11/20/2025) during the day shift and he was saturated with urine until night shift V11, CNA came in and helped clean him up and showered him. R9 stated V16 never offered to change his brief due to peeing at all that shift and he never refused care from her. On 11/21/2025 at 4:38 PM V11, CNA stated she worked night shift on 11/20/2025 and was assigned to R9. V11 stated she did rounds, and she entered R9's room there was a strong smell of urine. R9 told V11 that the day shift CNA V16 didn't take care of him all day and that he was soaked in urine. V11 stated she removed the blanket from R9 and it was so saturated with urine it was dripping urine on the floor and R9's bed was soaked with urine. V11 stated she immediately gave R9 a shower and got him cleaned up and R9 didn't refuse care from her at all. On 11/21/2025 at 11:35 AM V16, CNA stated she worked day shift on 11/20/2025 and was assigned to R9 from 7:00 AM to 7:30 PM. V16 stated she entered R9's room multiple times throughout the shift and asked if R9 needed anything and that he refused care and stated to get out of his room. V16 stated she didn't report R9 refusing care and thought he was just having a bad day and that he could take care of himself regarding incontinence. When night shift staff came in she did rounds with V11, CAN she noted R9 was saturated with urine and V11 stated she was going to tell on her that she didn't take proper care of him so she called V3, ADON after she had left the facility that R9 had refused care all day and that he was found saturated with urine when night shift arrived because she didn't want to get in trouble for not taking care of R9. V16 stated that was the first time she was assigned to take care of R9 and no staff gave her report on him and she didn't know R9 was incontinent of urine, she thought he used a urinal. V16 stated when she reported that R9 refused care to V3 that V3 told her he refused care for her on 11/16/2025 as well so she was aware he refuses care at times. On 11/21/2025 at 12:50 PM V3, ADON stated V16 called her in the evening on 11/20/2025 and stated R9 refused care from her all-day shift and that the night shift reported to her that R9 was soaked with urine because V16 didn't change his incontinence brief throughout her shift. V16 reported to V3 that she didn't know what to do and she didn't want to get in trouble for not taking care of R9 but that he refused all care from her, and she didn't know what to do. 2. R8's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] with diagnoses including dementia and anxiety. R8's care plan creation date, 6/5/2023 documents focus: resident has bladder incontinence. Interventions: check resident every 2 hours and assist with toileting as needed, provide bedpan/bedside commode, provide peri care after each incontinence episode. R8's Revised Care Plan, dated 5/6/2025 documents focus: resident is resistant to care, takes blankets off the bed when soiled and throws them on the floor. Interventions: try changing caregiver if resident is not cooperative with care, if resident resists with ADLs (Activities of Daily Living) reassure resident then leave and return later and try again. R8's Quarterly Minimum Data Set (MDS) dated [DATE] documents she is cognitively impaired, rejection of care occurred daily and incontinent of urine. R8's Progress Notes, dated 11/20/2025 no documentation of resident refusing care or what interventions were attempted to provide incontinence care overnight to R8. On 11/21/2025 at 9:38 AM R8 lay in bed with her eyes open. R8 was alert and stated, I am full of n***. There was a strong odor</p>		