(X6) DATE

Illinois Department of Public Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
,		1521111110711101111011152111	A. BUILDING: _			
		IL6001663	B. WING		06/27	7/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HIGHLAN	D HEALTH CARE CENTE	R 1450 26TH HIGHLAND				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investigation	on: 2444565/IL174183 2444602/IL174232				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations (1 of 2)				
	300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)					
	Section 300.610 Res	sident Care Policies				
	procedures governing facility. The written p be formulated by a Ro Committee consisting administrator, the admedical advisory comof nursing and other spolicies shall comply The written policies s the facility and shall be	of at least the visory physician or the simittee, and representatives services in the facility. The with the Act and this Part. hall be followed in operating se reviewed at least annually cumented by written, signed				
	Section 300.1210 Ge Nursing and Persona	eneral Requirements for I Care				
		ve Resident Care Plan. A ipation of the resident and				

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/09/24

TITLE

STATE FORM 5899 5XE411 If continuation sheet 1 of 12

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLET	ΓED	
	_	
IL6001663 B. WING 06/27	/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAND HEALTH CARE CENTER 1450 26TH STREET		
HIGHLAND HEALTH CARE CENTER HIGHLAND, IL 62249		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Continued From page 1 the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for		

Illinois Department of Public Health

STATE FORM 5899 5XE411 If continuation sheet 2 of 12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			_			;
		IL6001663	B. WING		06/2	7/2024
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
HIGHLAN	D HEALTH CARE CENTE	R 1450 26TH HIGHLAND				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
\$9999	made by nursing staff resident's medical red These Requirements Based on interview at failed to assist reside living for dependent rhygiene care for 1 of for Activities of Daily I residents in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in psychosod in the samp resulted in psychosod in the samp resulted in psychosod in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in psychosod would have been embedded in the samp resulted in the sa	f and recorded in the cord. were not met evidenced by: Ind record review, the facility ints with activities of daily esidents including oral and 4 residents (R2) reviewed Living (ADLs) for dependent intelle of 24. This failure cital harm as a normal person parrassed if they could not be eand be clean and odor	S9999	DEFICIENCY)		
	Calorie Malnutrition, I Hemorrhage, Aphasia Stage 3 Pressure Ulo (Peripheral Vascular I Seizures, Neurocogn Bodies, Dystonia, Hy Depressive Disorder R2's Minimum Data S R2 has severe cognit incontinent of bowel / with Activities of Daily R2's Care Plan, dated has an ADL self-care requires physical ass needs.	Non-Traumatic Extradural a, Parkinson's Disease, eer to the Sacral Area, PVD Disease), Dysphagia, itive Disorder with Lewy pernatremia, MDD (Major and HTN (Hypertension). Set, dated 6/9/24, documents ive impairment, is bladder and is dependent				

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 3 of 12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		, , ,	E SURVEY PLETED
						С
		IL6001663	B. WING		06	6/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E. ZIP CODE		
			H STREET	_,		
HIGHLAN	D HEALTH CARE CENTE	R	ID, IL 62249			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
S9999	Continued From page	e 3	S9999			
	Response), dated 6/9 the following: blood 78, respirations of 18 reason for transfer: gablockage or dislodger Unable to get any nut refused to eat or drink mental status or funct upon assessment, the connected to the resignation. Went to flush the Attempted to milk the through, and hot coffe was not successful. A get the clog out with resident to ED (Emerging 18 to 20 t	b/24 at 4:14 PM, documents pressure of 116/74; pulse of the temperature of 97.8; astrostomy tube (G-Tub) ment, G-tube clogged. The trition or fluids to resident, we by mouth. No change in the tional ability. This morning the G-tube feeding was not dent and leaking all over the eresident with no success. The tubing, pulsating fluids the tode-clog it however, whother nurse attempted to the success. Resident would ing that was offered. Sent gency Department) to get a notified at 11:20 AM; SBAR				
	local hospital for upda be transferred to outs (Intensive Care Unit) R2's ED Provider Not documents the follow a history of intracrania craniotomy, seizure d disease, dysphagia, f dependence presents malfunction. Upon arr severely tachycardic a (Systolic Blood Press exam: chronically ill w toxic appearing, neck mucous membranes, Foley catheter inserte	with a diagnosis of Sepsis. les, dated 6/9/24, ing: 75 year old female with al hemorrhage with lisorder, Parkinson's ailure to thrive and G-tube s with a reported G- tube rival, patient is appearing and hypotensive with SBP ure) 80's/50's. Physical with severe debility, acutely in contracture to right, dry cracked lips, tachycardic. ed in LUQ (left upper				
	1	y site. Perineal erythema				

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 4 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		IL6001663	B. WING	-	06	27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1450 26Ti	H STREET			
HIGHLAN	D HEALTH CARE CENTE	ER .	D, IL 62249			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THI DEFICIENCY		DATE
			+	BEI IOIEITOT,	<u>'</u>	
S9999	Continued From page	e 4	S9999			
	rooponoo to povious	otimuli apoptopoouo				
	response to noxious	emities, contractures to right				
		emities, no verbal response.				
		h) normal 0.4-2 MMOL/L;				
	, -	ormal 136-145. Problems				
		ney injury, hypochloremia,				
	severe, associated w					
	hypernatremia, sever	* *				
	••	shock, and supraventricular				
	_ · · · · · · · · · · · · · · · · · · ·	in worsening hypotension.				
	Cardioversion attemp	ted twice with adenosine				
	and was unsuccessfu	ıl. Returned to sinus				
	tachycardia following	5mg (milligrams) of				
	-	n: transfer to another facility				
	for ICU (Intensive Ca	re Unit).				
	P2's History & Physic	cal, dated 6/9/24, documents				
		old female with a past				
		umatic subdural hematoma				
		ng a craniotomy, Parkinson's				
		non-verbal, G-tube fed,				
		a and hypothyroidism				
		r from the local hospital.				
	Patient is non-verbal	at baseline and unable to				
	supply history. Histor	y is obtained from ED and				
	previous records. Pat	tient resides at a nursing				
	_	fed. She had issues with				
		gged several months ago				
		ter was put in place of the				
		tly never had a follow up				
	with Gastroenterolog					
		staff noted that her G-tube				
	· ·	ne was sent to the ED. On				
	arrival to the ED, pati					
		otes, she appeared dry and				
		She was noted to have poor				
		nouth, cracked lips, caked				
		ons on perineum and thighs,				
		excoriated skin that was				

Illinois Department of Public Health

STATE FORM 5899 5XE411 If continuation sheet 5 of 12

	ER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
		A. BUILDING: _	A. BUILDING:		
IL60	01663	B. WING		06/2	; ?7/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HIGHLAND HEALTH CARE CENTER	1450 26TH HIGHLAND				
(X4) ID SUMMARY STATEMENT OF DEPARTMENT OF D	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
difficult to clean. Physical exame excoriation/erythema of the inner with foul smelling drainage. Concabuse/neglect. On 6/14/2024 at 10:39 PM, V1, A stated R2 had a G-tube, it was of flush and they sent her to the local facility marketer spoke with the concerned about R2's state and facility provided. R2 was transfer local hospital to an outside hospital to an outside hospital to an outside hospital to an outside hospital while she was here, concerns at while she was here, concerns at she had an ongoing pressure uld sacrum, and they were upset and neglected her. On 6/20/24 at 3:15 PM, V10, Ref. RN, was contacted by telephone G-tube was clogged, and she was unclog it. V10 stated R2 looked it morning, normally doesn't talk, is that afternoon, she was pale and same as she had that morning be hadn't eaten all day. V10 stated ther to eat and drink, but she wou mouth. V10 stated R2 did have of feeding but were unable to admit the tube was clogged. V10 stated R2 had vaginal secretions or her pubic hair was matted or dry or it been completed. On 6/21/24 at 9:30 AM, V11, ED entered their ER on 6/9/24 from (Emergency Medical Services) at the contable to the contable to the contable to the completed.	Administrator, logged, would not cal ER. When the case manager at ily was the care the cred from the cal and was one of R2's sons ning. They were need id not have out her wound, cer on her d said the facility gistered Nurse, and stated R2's as unable to normal that a rigid. V10 stated I didn't look the ecause she they tried to get aldn't open her orders for tube inister it because d she isn't sure if a pubic area/ f oral care had	S9999			

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 6 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
						С
		IL6001663	B. WING		06	/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	D	1450 26T	H STREET			
HIGHLAN	D HEALTH CARE CENTE	ER HIGHLAN	ID, IL 62249			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLETE DATE
TAG	REGULATORTOR	EGG IDENTIL TING INI GRAVIATION)	TAG	DEFICIENC		2,2
S9999	Continued From page	- 6	S9999			
39999	Continued From page		39999			
		illy non-verbal. V11 stated				
		d to the right side, her lips				
		d, there was a film coating				
		had a scab on it and was				
		R2's vital signs upon arrival				
	were 85/64 (blood pre					
	, , , , , , , , , , , , , , , , , , , ,	spirations), 119 (heart rate),				
		3 pounds). V11 stated she				
		velling urinary catheter and				
	-	adhered to her labia from				
	_	nd she had sloughing on the her diaper. V11 stated she				
	_	neal area before she could				
	-	e catheter. V11 stated once				
	_	erted, she only had 20cc				
		f return urine after having a				
		nously). V11 stated R2 had				
		her mouth and perineal				
		was told by the nursing				
		be was clogged, and she				
		on since the night before				
	and nothing was don	e about it until the day shift				
	came in. V11 stated s	she was very concerned with				
	R2's lack of hydration	and that R2 hadn't received				
	basic care at the facil	lity when she was sent to the				
	ED on 6/9/24.					
	On 6/27/24 at 0:10 Δ	M, V38, R2's Son, stated R2				
		barrassed and would not				
		hospital or in public without				
	_	h brushed and without				
		was a nurse and spent her				
		and would have wanted to be				
	_	way she cared for them.				
		arkinson's Disease, is				
		hands are curled up, she				
	must be fed and need	ds complete care.				
	The Desire 10 5					
	The Perineal Care Pr	ocedure, undated, ses of this procedure are to				
	i aocamento tre pulbo	ises of this procedure are to	1	1		

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 7 of 12

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		' '	CONSTRUCTION		E SURVEY PLETED	
			71. 50.25.110.			0
		IL6001663	B. WING		06	C 5/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	F ZIP CODE	•	
			H STREET			
HIGHLAN	D HEALTH CARE CENTE	R	ND, IL 62249			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
S9999	Continued From page	e 7	S9999			
	nrovide cleanliness a	nd comfort to the resident, to				
	1 -	d skin irritations and to				
	observe the resident's					
		, with a review date of				
		e purposes of this procedure				
		ent's lips and oral tissues				
		freshen the resident's				
	mouth and to prevent	oral infection.				
	(B)					
	Statement of Licensu	ure Violations (2 of 2)				
	300.615e)					
	300.615(f)					
	Section 300.615 Dete	ermination of Need				
		est for Resident Criminal				
	History Record Inform					
	,	creening required by Section				
	1 ' '	and this Section, a facility				
	shall, within 24 hours					
		iminal history background				
	check pursuant to the	persons 18 or older seeking				
		ity, unless a background				
		y a hospital pursuant to the				
	-	t. Background checks shall				
		dent's name, date of birth,				
	and other identifiers a	as required by the				
		Police. (Section 2-201.5(b)				
	of the Act)					
		eck for the individual's name				
		ender Registration website				
		and the Illinois Department gistrant search page at				
		o determine if the individual				

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 8 of 12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		IL6001663	B. WING		06	C 5/27/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	1 00	<i>3/21/202</i> 4
	D HEALTH CARE CENTE	1450 26T	H STREET			
HIGHLAN	D HEALTH CARE CENTE	HIGHLAN	ID, IL 62249			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 8	S9999			
	is listed as a registere	ed sex offender.				
	This requirement is N	OT Met as evidence by:				
	failed to check the Illii Corrections sex regis Illinois Sex Offender I during preadmission s documentation for time background checks for R14, R17, R18, R19, R24) reviewed for background checks for sample 24. This has the residents living in the as aggravated criminal	trant search page and the Registration search page screening and failed to show hely initiation of criminal or 10 of 10 resident (R10, R20, R21, R22, R23 and ckground checks in the he potential to affect all 168 facility. (R14) was identified al sexual abuse offender ss than 500 feet from a				
	Findings include:					
		PM, sounds of children re heard from inside the are across the street.				
	documents a diagnos	er Sheets for June 2024 is of Parkinson's Disease story of fractures, and				
	(R14) has a history of evidence by (R14's) to Care Plan created da "Assist the resident in reporting if the terms reporting (i.e., for a re	egistered sex offender)."				
	On 6/20/2024 at 9:03 for R14 were request	AM, all background checks				

Illinois Department of Public Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		GOWII ELTED
		IL6001663	B. WING		C 06/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HIGHLAN	D HEALTH CARE CENTE	ER .	H STREET D, IL 62249		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
S9999	Continued From page	9	S9999		
	was admitted to the fi 2:03PM. R14's backg on 4/11/2024. R14's criminal history documents, one conv offense of aggravated	ning Record documents R14 acility on 1/29/2024 at ground check was completed with the State Police viction in 1990 for the d criminal sexual abuse. He			
	was sentenced to four Date of arrest 3/9/199	r years of incarceration. 90.			
	On 6/20/2024 at 9:30 AM during review of R14's Preadmission Screening documents, the Illinois Department of Correction Search and the Illinois Sex Offender Registration search was not in the screening documents.				
	stated, "(R14) is on o identified as an identi sexual assault and si feet from the daycare	2 PM, V1, Administrator ne on ones because he was fied offender and it was nce we are less than 500 e across the street, we gave scharge that his wife is trying			
	Preadmission Screen Department of Correct Sex Offender Registr	AM, during review of R10's ning documents, the Illinois ction Search and the Illinois ation search was not in the s or provided by the facility.			
	Preadmission Screen Department of Correct Sex Offender Registr	AM, during review of R17's ning documents, the Illinois ction Search and the Illinois ation search was not in the cor provided by the facility.			
	On 6/24/2024 at 7:40	AM, during review of R18's			

Illinois Department of Public Health

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			D. WING			С
		IL6001663	B. WING		06	3/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HIGHLAN	D HEALTH CARE CENTE	1450 26T	H STREET			
	S HEXETT ON THE GENTLE	HIGHLA	ND, IL 62249			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 10	S9999			
	Preadmission Screen Department of Correct Sex Offender Registra screening documents On 6/24/2024 at 7:45 Preadmission Screen Department of Correct Sex Offender Registra screening documents On 6/24/2024 at 7:50 Preadmission Screen Department of Correct Sex Offender Registra screening documents On 6/24/2024 at 7:55 Preadmission Screen Department of Correct Sex Offender Registra screening documents On 6/24/2024 at 7:55 Preadmission Screen Department of Correct Sex Offender Registra screening documents	aing documents, the Illinois ation Search and the Illinois ation search was not in the sor provided by the facility. AM, during review of R19's aing documents, the Illinois ation Search and the Illinois ation search was not in the sor provided by the facility. AM, during review of R20's aing documents, the Illinois ation search was not in the sor provided by the facility. AM, during review of R21's aing documents, the Illinois ation search was not in the sor provided by the facility. AM, during review of R21's aing documents, the Illinois ation Search and the Illinois ation search was not in the sor provided by the facility. AM, during review of R22's				
	Preadmission Screen Department of Correct	ning documents, the Illinois ction Search and the Illinois ation search was not in the				
	o On 6/24/2024 at 8: R23's Preadmission S Illinois Department of Illinois Sex Offender I	or provided by the facility. 05 AM, during review of Screening documents, the Correction Search and the Registration search was not uments or provided by the				
	Preadmission Screen Department of Correct	AM, during review of R24's ning documents, the Illinois ction Search and the Illinois ation search was not in the				

Illinois Department of Public Health

STATE FORM 5XE411 If continuation sheet 11 of 12

NAME OF PROVIDER OR SUPPLER ILEGO1663 NAME OF PROVIDER OR SUPPLER SUMMARY STATEMENT OF DEPCEMENTS HIGHLAND, IL. 62249 WAY ID SHADEN STATEMENT OF DEPCEMENTS IN STATEMENT OF DEPCEMENTS IN SUMMARY STATEMENT OF DEPCEMENT OF DEPCEMENTS IN SUMMARY STATEMENT OF DEPCEMENT OF DEPCEMEN		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
IL6001663 B. WING D6/27/2024				A. BOILDING.			
HIGHLAND HEALTH CARE CENTER 1450 26TH STREET HIGHLAND, IL 62249 (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 11 Screening documents or provided by the facility. On 6/20/2024 at 10:02 AM, V1, Administrator stated, "I gave you everything I have for background checks for everyone." The Facility's Abuse Policy with a revision dated of 1/9/2024 documents, "Conducting Pre-employment screening of employees and pre-admission screening of residents." The Long-Term Care Facility Application for Medicare and Medicaid dated 6/21/2024 documents there are 168 residents living in the facility.			IL6001663	B. WING		I	
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Illinois Department of Public Health

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