STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: _____ B. WING _____	C 04/17/2025

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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S 000	Initial Comments Complain Investigation 2543529/IL190199 - F600 cited	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) Section 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

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Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent resident to resident sexual abuse for 1 of 1 (R2) residents reviewed for abuse in the sample of 4. This failure resulted in psychosocial harm in that, a reasonable person would react to such a situation with feelings of anxiety, distress, fearfulness and humiliation. This past compliance occurred from 4/14/2025 to 4/15/2025.

Findings include:

1.R2's Undated Face Sheet documents he was initially admitted to the facility on 3/5/2025 with diagnoses including dementia, psychotic disorder with hallucinations and post traumatic stress disorder (PTSD.)

R2's MDS, dated 3/12/2025 documents he is cognitively impaired.

R2's Care Plan, dated 3/6/2025 staff documented potential for abuse and was also care planned for history that indicates he may have experienced significant trauma during his lifetime. Resident identified trauma related to triggers include people grabbing and observations of other being grabbed.

R2's ER (emergency room) documentation, dated 4/14/2025 patient presenting for evaluation of

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possible sexual assault. Patient was coming from VA (Veterans Association) hospital with transfers apparently, they cannot evaluate any type of sexual assault. Patient reports over the weekend believe was Saturday he was groped by a facility member there. Patient reports he was squeezed on his buttocks reports no handing of his genitalia including testicles or penis. Patient denies anything entering his rectum or any pain around his anus. Patient denies any rash or discharge. Police have been contacted. ED progress note documents patient reports he was groped apparently was squeeze down his buttocks. Did perform visual exam which was unremarkable. Did discuss with patient and family on obtaining forensic evidence such as a rape kit which at this time did not see any need for as there was no insertion injury. Clinical impressions documented: sexual assault by bodily force by caregiver.

On 4/16/2025 at 8:15 AM V2, Director of Nursing (DON) stated V1 is the Administrator, and they were notified of residents having an incident on 4/15/2025, that involved (R1) and (R2) and that both resided on the dementia unit and (R2) is not interviewable. She stated (R1) was moved from the dementia unit after the allegation and is now on a 1:1 with staff. V2 stated neither resident have a history of sexual touching between themselves or others. V2 stated (R1) was walking down the hall and came up to (R1) and touched his butt both residents had clothes on at the time and staff separated them immediately. V14, Registered Nurse (RN) was the nurse and V12 was the CNA, this incident occurred on 4/13/2025 at approx. 8:00 PM. V2 stated (R2) is out of the facility for a physician's appointment today and isn't expected back until late this evening.

On 4/16/2025 at 9:14 AM V1 stated V11, Case

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Manager at the veteran's association primary care office called the facility on 4/14/2025 at approximately 10:00 AM and stated (R2) stated he was grabbed on the back side by (R1), he started an investigation at that time. V1 stated neither resident has a history of sexual touching.

A Witness Statement, dated 4/14/2025 V11, VA (Veteran's Association) Nursing Home Consultant documents (R1) presented to ED for medical evaluation. Another resident attempted to sexually assault him in the facility and stated a hand was fully into his rectum, being sent to another hospital for sexual assault evaluation.

On 4/16/2025 at 2:14 PM V11, VA Nursing Home Consultant stated she called the facility to notify them of the allegation of sexual abuse on 4/14/2025 and she reported what was (R2's) VA medical record, that is where she got the information from. The VA social worker referred (R2) to a local ER because they do not do sexual assault kits at the VA. V11 stated she read (R2's) hospital paperwork and noted it documents a different version of what occurred to (R2) and she wasn't sure what actually occurred in the incident but that she reported what (R2's) VA medical record documented.

A Witness Statement, dated 4/14/2025 V12, Certified Nurse Aide (CNA) documented, "Yes, I provided care for him (R2) his family was with him and completed routine checks. Family arrived around 12:00 PM and left and came back. Family was still here when I left at 8:45 PM. V13, R2's family member reported that another resident touched his butt. I reported it to V14, RN around 8:20 PM (R2) stated R1 touched his (R2) butt around 8:15 PM. (R2) stated that resident (R1) came up from behind and first grabbed his arm

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then grabbed his butt with both hands.

On 4/16/2025 at 12:50 PM V12, CNA stated he worked 4/14/2025 day shift and stayed a few hours extra to help out and was assigned to (R2.) Around 8:20 PM (R2's) family member (V13) reported to him that (R1) grabbed (R2's) buttocks and he reported it to V14, RN immediately. He spoke to (R2) and he told him that (R1) walked up being him and grabbed his buttocks with both hands. V12 stated (R2) is alert with bouts of confusion but that he was very alert when he spoke to him regarding the incident. V12 stated he didn't witness (R1) grope or touch (R2.)

An Undated Witness Statement, documented V14, RN, "Yes I provided care for (R2). He voiced that (R1) touched him on the butt in the TV room, he doesn't like it because (R2) will trigger him and he doesn't want to hurt her.

On 4/16/2025 at 10:40 AM R1 was observed sitting with V15, Activity Aide. R1 stated she doesn't do anything with any man other than her husband and stated she didn't touch anyone inappropriately and she would never do that.

On 4/16/2025 at 4:30 PM, V14, RN stated she worked 4/14/2025 and was the assigned nurse to (R1) and R2. Sometime during the evening of 4/14/2025 (R2) was upset and reported to her that (R1) grabbed his buttocks in the activity room, and he stated it wasn't appropriate and that he doesn't want (R1) touching him ever again. V14 stated she didn't witness the incident between the residents, but she reported the incident to V1 immediately.

On 4/16/2025 at 4:20 PM, V13 R2's family member stated he came to visit (R2) on the

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evening of 4/14/2025 and (R2) told him that a lady groped his buttocks with both hands, and it triggered him and he felt embarrassed to tell him about it but he didn't want to be groped by the lady again. V13 reported it to the nurse on duty at that time, V14 and she reported she would let Administration know of the incident. V13 stated he was upset that the VA office he initially took (R2) to be assessed documented that (R2) reported the female put her hands down his pants and touched (R2's) rectum because he was with (R2) the entire time he was at the VA office and (R2) never reported that occurred. V13 stated when they got to the hospital that staff wanted to do a rectal exam on (R2) declined it stating no one touched his rectum.

On 4/16/2025 at 4:50 PM R2 was observed walking around his room. He was alert and stated a few days ago (exact date unknown) a female resident ran up from behind him, pulled down his pants and grabbed his buttocks, R2 showed how the female resident (R1) grabbed his buttocks by grabbing a pillow and he showed how she grabbed his buttocks with both fists and squeezed really hard. R2 stated he felt terrible about it and was very embarrassed because it occurred in front of other residents. When (R1) grabbed his buttocks like that he screamed because it hurt. (R1) grabs at him and other residents often and he's told her time and time again don't touch me, I don't like being touched. If it was a man that grabbed me like that he would have been on the floor with a knock out punch to the face but since it was a female I just walked away from the situation but she better not grab me ever again like that.

On 4/16/2025 at 11:00 AM V4, Social Services Director stated V2, DON reported to her on

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4/14/2025 that (R2) went to an outside physician's appt and the office called and stated (R2) told them that a female resident grabbed his bottom the day before. She spoke to (R2) the same day and he told her he didn't want to be grabbed on his buttocks by other residents he didn't report the name of the resident that grabbed his buttocks he said some old lady grabbed his buttocks. V4 stated (R2) wasn't crying when she spoke to him about the incident he just stated he doesn't want his buttocks to be grabbed because it could trigger him. V4 stated she will follow up with him with the psychosocial assessment every 3 days for 30 days to see how he's doing regarding the incident. V4 attempted to interview (R1)but she didn't respond to any questions regarding her touching (R2's) buttocks. V4 stated neither resident has a history of sexual touching in the past but (R1) does has a history of grabbing residents but this is the first time she grabbed a resident inappropriately and she's been on 1:1 for this behavior since the incident was reported on Monday 4/14/2025. V4 stated the incident occurred on the dementia unit and since the incident occurred (R1) was moved from the dementia unit.

The Facility's Abuse Policy, revised 1/9/2024 documents purpose: to provide guidance and procedures to the facility to assure the residents remain to be free from abuse. This facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse of residents. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse and mistreatment of residents.

(B) PNC