STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510226	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH POINT RESIDENCE TAYLORVILLE	920 MCADAM DRIVE TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident 4/14/25 IL190180	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Violation Type 2 Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the Establishment failed to ensure that residents are free from abuse from their peers. This failure caused substantial harm to a resident when (R2) pushed (R1) causing (R1) to fall and be hospitalized with a brain bleed. Findings include: The Establishment's Prevention of Resident Abuse, Neglect and Misappropriation of Resident Property Policy, dated 12/2024 documents, "Procedure : Every resident living at our facility has the right to be free from abuse, neglect and misappropriation of his/her property. Our facility will enforce policies and procedures intended to protect each resident from abuse, neglect and misappropriation of property by employees of our facility, other residents, consultants, volunteers,	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510226	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH POINT RESIDENCE TAYLORVILLE	920 MCADAM DRIVE TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A6000	Continued From page 1	A6000		

employee or other agencies serving the residents, family members and legal guardians, friends, or other individuals."

The Establishment's reportable incident, Corrected date 4/13/25 at 4:10 PM documents: "Description: Incident/Accident, including impact on residents. A resident to resident altercation was observed involving (R1) and (R2). (R2) attempted to enter a female's room, (R1) was walking by the room at this time, followed him, and began to tell (R2) that this wasn't his room. (R2) pushed (R1), resulting in (R1) hitting his head on the adjacent wall. (R1) then slid onto the floor." Description of Action Taken: (R1) and (R2 were) immediately separated, staff redirected (R2) removing him from the area and placing him on frequent visual checks. The nurse assessed both resident for injuries, noting a bump to (R1's) head. (R1) was sent to the emergency room via ambulance for further evaluation."

R1's record documents that on 4/13/2024 "resident hit by another resident and resident fell backwards hitting head on wall then floor." R1's record documents after investigation "The other resident pushed this resident causing him to fall back into the adjacent wall hitting his head."

R1's hospital record documents a hospitalization on 4/13/2024 through 4/15/2025 being admitted with a small/minimal acute subarachoniod hemorrhage involving left parietal lobe-no focal neurological deficit on exam.

On 4/21/25 at 9:00 AM, E1/Administrator confirmed that R1 and R2 became in a verbal altercation when R2 had wandered into the wrong room and R1 approached him telling him it wasn't his room. E1 stated that R2 did push R1 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510226	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH POINT RESIDENCE TAYLORVILLE	920 MCADAM DRIVE TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A6000	Continued From page 2 resulted in R1 hitting his head on the wall and falling to the floor and that R1 was admitted to the hospital for observation and was diagnosed with a brain bleed and has since returned to the facility.	A6000		