STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Hlthcr of Woodstock	309 McHenry Avenue Woodstock, IL 60098

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(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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview, and record review the facility failed to ensure a resident that was on an oral anticoagulant medication (blood thinner) was free from physical abuse. This applies to 2 of 3 residents (R12, R13) reviewed for abuse in the sample of 15. This failure resulted in R12 complaining of 5/10 sharp pain to right parietal and temporal area during head examination. The findings include: 1. The facility's Final Abuse Investigation dated 3/18/25 documents on 3/16/25, (R12) reported that (R13) allegedly hit her on the head (R12) reported that she was backing out of the common area with her wheelchair and mistakenly ran into (R13) and (R13) hit her. R13's face sheet shows R13 is a [AGE] year-old male with diagnosis including bipolar, paranoid schizophrenia, schizoaffective disorder, unspecified mood (affective) disorder, anxiety, disorders of and psychosocial development. R12's progress notes printed 3/18/25 at 3:16pm in part documents diagnosis of chronic respiratory failure with hypoxia, vitamin deficiency unspecified, obstructive sleep apnea, gastro-esophageal reflux disease without esophagitis, essential hypertension, other chronic pain, obstructive hypertrophic cardiomyopathy, adjustment disorder with mixed anxiety and depressed mood, presence of left artificial hip joint, muscle weakness and chronic obstructive pulmonary disease unspecified. On 3/18/25 at 9:00 AM, V1 (Administrator) said an allegation of physical abuse was reported on 3/16/25. R12 and R13 were in the dining room, R12 was backing up in her wheelchair and bumped into R13. V1 confirmed R13 hit on R12 the head. On 3/18/25 at 9:27 AM, R12 was in her room lying in her bed. She said, Oh there was an incident. She was in the dining room during the noon meal on 3/16/25. She said she was backing up from her wheelchair and accidentally bumped into R13. R13 who gets easily angered punched me on the right side of my head with a closed fist several times. I've heard of him hitting others and I don't know why they don't do something. He clobbered me and he's a hazard. She said there was no staff in the dining room at the time and R15 witnessed what happened. An egg size bump to the back right side of R13's head was palpated. R13 said it's sore and it hurt. She said she doesn't think R13 belongs in this facility, he's not right. They used to have someone with him all the time, I don't know what happened to that. Sometimes we are understaffed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 11:33 AM, R13 was observed self-propelling himself in his wheelchair in the hallways. He was disheveled, unkempt, with a strong body odor. He was alert to self and unable to answer questions appropriately. On 3/18/25 at 1:24 PM, R15 said she was in the dining room on 3/16/25. They were at the table finishing lunch, R13 was trying to pass R12. He was ramming his wheelchair into her wheelchair. R12 said give me a minute and R13 started ramming his wheelchair harder into R12. R12 was backing up in her wheelchair and accidentally bumped into R13. R13 stood up from his wheelchair and hit her on the head with his fist several times. He was going to swing another time and he fell back into his wheelchair. He then left the dining room. There was no staff in the dining room at the time, they were taking residents back to their rooms after lunch. On 3/18/25 at 12:13 PM, V5 (Social Services) said R13 hit R12 in the head while in the dining room on 3/16/25. R13 could not recall the incident. Hitting another resident is physical abuse. V12's (Nurse Practitioner) progress note dated 3/17/25 documents in part (R12) is alert and oriented, per nursing request (to see resident) after another resident hit (R12) in the head on 3/16/25. (R12) reports backing up her wheelchair and accidently into another resident. (R12) stated, he hit me in the head several times. Bleeding precautions from OAC (oral anticoagulant). C/o (complains of) 5/10 sharp pain to right parietal and temporal area during head examination. Patient taking Eliquis 5mg po (orally) BID (twice a day) and educated on bleeding precautions. Will order neuro checks q (every) 4 hrs (hours) x 24hrs and will re-evaluate. Will order cold compress 20 minute duration over right parietal/scalp pain q shift and PRN (as needed) until pain resolved. Anxious while discussing incident on 3/16/25 and in the setting of pain. The facility's witness statement by V15 (Registered Nurse) on duty and V16 (Certified Nursing Assistant) said they did not witness the incident. The facility's Abuse Policy reviewed 11/2024 states, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent, abuse, neglect .abuse means the willful infliction of injury .willful means the individual must have acted deliberately physical abuse includes but not limited to hitting, slapping, punching, biting, and kicking .

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview, and record review the facility failed to supervise a resident who wanders and has physical aggressive behaviors towards others. This applies to 2 of 15 residents (R12, R13) reviewed for safety in the sample of 15. The findings include: 1. R13's face sheet shows he is a [AGE] year-old male with diagnosis including bipolar, paranoid schizophrenia, schizoaffective disorder, unspecified mood (affective) disorder, anxiety, disorders of and psychosocial development. The facility's Final Abuse Investigation dated 3/18/25 documents on 3/16/25, (R12) reported that (R13) allegedly hit her on the head (R12) reported that she was backing out of the common area with her wheelchair and mistakenly ran into (R13) and (R13) hit her. The Final report shows (R12) stated staff members were in the dining room monitoring them all along and this happened before the staff could stop (R13). (R12) stated the staff separated (R13) from her .residents who witnessed this allegation stated, (R12) ran into R13 with her wheelchair and (R13) hit (R12) .residents who witnessed this allegation stated the staff were in the dining room . resolution . staff will continue to monitor the residents activity/dining room to prevent future incidents. V15 (Registered Nurse/RN) and V16 (Certified Nursing Assistant/CNA) written statements dated 3/16/25 shows they did not witness the incident. On 3/18/25 at 9:27 AM, R12 was in her room lying in her bed. She said, Oh there was an incident. She was in the dining room during the noon meal on 3/16/25. She said she was backing up from her wheelchair and accidentally bumped into R13. R13 who gets easily angered punched me on the right side of my head with a closed fist several times. I've heard of him hitting others and I don't know why they don't do something. He clobbered me and he's a hazard. She said there was no staff in the dining room at the time and R15 witnessed what happened. An egg size bump to the back right side of her head was palpated, she said, it's sore and it hurt. She said she doesn't think R13 belongs in this facility, he's not right. They used to have someone with him all the time, I don't know what happened to that. Before this he was not supposed to be in our dining room. On 3/18/25 at 11:33 AM, a sign posted outside of the dining room highlighted in yellow Attention all staff/CNAs There must be at lease 1-CNA in the dining room at all times during the following mealtimes, breakfast, lunch, and dinner. R12 was sitting in her wheelchair in the dining room with R15. R13 was observed in the hallway outside of the dining room self-propelling in his wheelchair. R12 said there he is in the hall. She told the staff You better get him if comes in. At 11:37 AM, R13 entered the dining room, R12 stated, here he comes, he's coming. Staff told R13 he has to go to the other dining room. At 11:42 AM, R13 was in the hallway sitting in his wheelchair going up and down the halls. At 11:51 PM, he remained in the hallway. At 12:00 PM, he yelled HEY when a staff member passed him by. At 1:38 PM, R13 remained in the hallway with no staff observing him self-propelling the halls. At 2:30 PM, R13 was sitting in the dining room during the bingo activity with several residents in the same area. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 1:24 PM, R15 said she was in the dining room on 3/16/25. They were at the table finishing lunch, R13 was trying to pass R12. He was ramming his wheelchair into R12's wheelchair. R12 said give me a minute and R13 started ramming his wheelchair harder into R12. R12 was backing up in her wheelchair and accidentally bumped into R13. R13 stood up from his wheelchair and hit her on the head with his fist several times. He then left the dining room. There was no staff in the dining room at the time. They were taking residents back to their rooms after lunch. R15 said R13 is still wandering the facility, that makes me uncomfortable, he used to have a one to one, and he's not supposed to be in either dining rooms because of his behaviors, he's supposed to eat in his room. Unfortunately, we don't enough staff, just seeing him makes me nervous. On 3/18/25 at 10:55 AM, V7 (CNA) said R13 is combative, he has unpredictable behaviors. He wanders and use to have a 1:1, now he's not. She was R13's CNA on 3/16/25 when the incident happened. She was not in the dining room, R13 usually eats his meals in his room, because he eats better in his room. I don't know why he was over in the dining room he likes to hang out there. He does not need any special monitoring. He can wander throughout the facility. On 3/18/25 at 11:52 AM, V6 (Licensed Practical Nurse/LPN) said R13 has a history of schizophrenia, he had behaviors including agitation, anxiety and heard of him getting physical with other residents. He is alert to self. R13 likes to wander we constantly have to check on him and R13 needs to be supervised. On 3/18/25 at 12:13 PM, V5 (Social Services) said R13 has behaviors including physical behaviors with residents and staff. We are trying to find a more appropriate place for him, have sent several referrals to many psych facilities and we keep on getting denied due to his behaviors. He has his own room, he is followed by psych, at one time he had a one-to-one sitter for safety, he should be monitored by staff every 15 minutes. On 3/18/25 at 2:00 PM, V2 (Director of Nursing/DON) said R13 came from a psych facility, we have been looking for placement for him after his first physical behavior with another resident. R13 gets agitated, he gets easily provoked, very resistant with cares. Staff should keep an eye on him, checking to see where he is, he has difficulty focusing. We try not to put him in super crowed area, he likes to spend time in his room. He has been on special monitoring, but not anymore. Most of the residents do know him, and certain residents will not go where he is. Having less stimulus around him works best, he does not do well in large settings. We wander and we don't want to restrict him, she heard about the incident on 3/16/25 from another nurse working that day. An agency nurse was R13's nurse that day, she said she did not know about the incident. R13 was sent out on 3/16/25 for his behaviors and returned to the facility. R13's Psychiatry Progress note dated 2/3/25 documents chief complaint altered mood and behavior, aggression. (R13) was sent toER on [DATE] due to behaviors of physical and verbal aggression returning the same day. His psychiatric condition has required constant monitoring and intervention with ongoing challenges in medication and compliance and behavior management. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's current care plan shows he has behavioral symptoms related to schizophrenia, bipolar, mood and anxiety disorder, these behaviors are manifested by increased agitation, poor impulse control, and becoming physically aggressive with residents and staff. The care shows he eats all meals in the main dining room rather than 300 dining room apart from resident he had altercation from (11/15/24-had a physical altercation with another resident) .provide 15-minute checks to monitor behaviors. The care plan shows on he had physical altercations with staff on 11/18/24 and 12/13/24. The care plan does not show any new interventions implemented since 11/15/24. 47552

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47552 Based on observation, interview, and record review the facility failed to ensure dietitian recommendations for an increased tube feeding order were carried out. This failure resulted in R8 experiencing a significant weight loss of 13.9% in 6 months. This applies to 1 of 3 residents (R8) reviewed for weight loss in the sample of 15. The findings include: R8's Face sheet dated 3/18/25 shows R8 has diagnoses that include but are not limited to: dysphagia following cerebral infarction, acute metabolic acidosis, and abnormal weight loss. On 3/17/25 at 12:23 PM, R8 was lying in bed with the head of bed elevated approximately 30 degrees. R8 was not receiving a bolus feed at that time. R8 showed some signs of muscle wasting on his collar bones and cheeks. R8 was unable to make his needs known verbally but was able and willing to provide a thumb up for a yes and a thumb down for a no. When asked if they provided a bolus feed via syringe through his percutaneous endoscopic gastrostomy (PEG) tube two times that day, the resident gave a thumbs up. R8's Weights and Vitals Summary dated 3/18/25 shows R8's current weight is 149 pounds (lbs) and was taken on 3/15/25. R8's six-month weight taken on 9/18/24 shows R8 weighed 173 lbs. This is a difference of 24 pounds, or 13.9%. R8's Nutrition/Dietary Note dated 12/31/24 shows V4 (Registered Dietitian) recommended to increase R8's feeding to a different formula and volume which would provide an additional 90 calories to promote weight gain. R8's discontinued physician's order report does not show this recommendation was ever updated and R8 continued on the lower calorie formula until 3/7/25, when it was discontinued. On 3/18/25 at 3:25 PM, V4 stated she has been seeing R8 since R8's admission to the facility. V4 sees R8 at least twice monthly, or more, and writes a progress note at least once monthly. V4 is unsure of the accuracy of R8's admission weight and believes R8 to have a more accurate usual body weight around 158 lbs. V4 said even with that information, R8 is down 10 pounds from that, and it is a concern. V4 stated R8 is reliant on his tube feeding for all his nutrition. V4 said she has changed formulas, changed bolus volumes, and has even attempted to provide R8 with a continual tube feeding with no success on preventing V4's weight loss. V4 said all formulations were calculated to provide 100% of R8's daily needs and should have at a minimum provided R8 with weight stability and possibly even gradual weight gain. V4's goal for R8 is for gradual weight gain and to prevent further weight loss. Facility Weight Monitoring policy dated 10/2024 states, Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47552 Based on interview and record review the facility failed to ensure a resident received their medications. This applies to 1 of 1 resident (R2) reviewed for medications in the sample of 15. The findings include: R2's Face sheet shows R2 has diagnoses that include but are not limited to; acute combined systolic (congestive) and diastolic (congestive) heart failure, acute and chronic respiratory failure, lymphedema, hypertension, anemia, and hypokalemia. On 3/17/25 at 9:25 AM, R2 said V10 (Licensed Practical Nurse/LPN) doesn't provide his diuretic and potassium pills at the correct time, and he frequently gets delayed medications. R2 also stated that his legs were no longer weeping fluid, the fluid in his legs has decreased, and he no longer needs to wear tight bandages on his legs. On 3/18/25 at 9:35 AM, V10 (LPN) said for roughly a month or longer, V10 stopped caring for R2 when V10 worked, because R2 would get verbally aggressive towards V10 and use racial slurs against V10. V10 is no longer comfortable providing care for R2 and does not provide V10 medications. V10 said the nurse that is working another unit or V2 (Director of Nursing) will typically provide R2 with R2's medications when V10 works on R2's unit. V10 said the nurse who provides R2 with R2's medication will sign the medication administration record (MAR) after it is provided. R2's January 2025 MAR shows R2 did not receive his morning diuretic and potassium medications on 1/28/25, 1/30/25, and 1/31/25. R2's February 2025 MAR shows R2 did not receive his morning diuretic and potassium medications on 2/4/25, 2/6/25, 2/7/25, 2/8/25, 2/11/25, 2/13/25, and 2/23/25. R2's March 2025 MAR shows R2 did not receive his morning diuretic and potassium medications on 3/9/25. Facility nursing schedule for January, February, and March of 2025 shows V10 (LPN) worked on R2's unit on each of the days that R2 had medications not given. On 3/18/25 at 9:35 AM, V10 said if a medication is not signed off in the MAR, it can be interpreted that the medication was not provided. On 3/18/25 at 12:53 PM, V14 (LPN) said she works with V10 every once in a while and will sometimes provide R2 with R2's medication and will sign the MAR when that happens. V14 said it does not happen every time V14 works with V10. On 3/18/25 at 11:38 AM, V2 (Director of Nursing) said she knows that V10 does not provide R2 his medications because of the behaviors R2 exhibits towards V10. V2 said when she is at the facility, she will provide R2 his medications and will sign the MAR when that happens. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 10:37 AM, V11 (Nurse Practitioner) said she was not aware or ever notified that there were times that R2 was not receiving his diuretic or his potassium medications. V11 said she saw R2 on 1/30/25, 2/5/25, and again on 3/13/25 and R2 exhibited no signs of shortness of breath or fluid overload and R2 even expressed to V11 that he feels like he has lost weight. V11 said R2 should have been receiving his medications as ordered.