

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER Highlight Hlthcr of Woodstock		STREET ADDRESS, CITY, STATE, ZIP CODE 309 McHenry Avenue Woodstock, IL 60098	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47552</p> <p>Based on interview and record review the facility failed to ensure a resident was free from verbal abuse from another resident. This applies to 2 of 4 residents (R5 and R6) reviewed for abuse in the sample of 6.</p> <p>The findings include:</p> <p>R6's Face Sheet dated 3/31/25 shows R6 has diagnoses that include, but are not limited to: adjustment disorder with mixed anxiety and depressed mood and other specified depressive episodes.</p> <p>R5's Care Plan initiated 10/23/24 shows that R5 has a history of becoming verbally aggressive towards staff.</p> <p>On 3/31/25 at 1:35 PM, V9 (Certified Nursing Assistant- CNA) said towards the end of V9's shift on Saturday, 3/29/25, V9 was providing care to another resident when V9 entered the hallway and saw R5's call light on. Without going to R5's room, V9 asked R5 what R5 needed and R5 responded saying R5 needed water. V9 acknowledged R5's request and told R5 that V9 will get R5 water when V9 finished caring for the resident V9 was working with. When V9 finished and exited the other resident's room, V9 saw that R5's call light was no longer on and had believed the other CNA working the hall had responded to R5's request so V9 did not get R5 water.</p> <p>On 3/31/25 at 11:12 AM, R5 said around 7:00 PM on 3/29/25, R5 put on R5's call light to request for water and ice from the CNA. R5 said at approximately 7:05 PM, V9 called to R5 saying V9 would be with R5 in a minute. At that time, R5 said R5 turned off the call light because V9 had acknowledged V9 would help R5. R5 said no staff returned to check on R5 and at 8:00 PM, R5 turned the call light back on. At 8:45 PM, V9 had returned to R5's room inquiring what R5 needed. It was at this time that R5 began arguing and yelling at V9 for not getting R5 water and R5 yelled get the f*ck out of here and threw a plastic cup with water in it at V9. After V9 exited the room, R5 heard R6 yell from another room for R5 to shut up, go to bed and to respect the staff. R5 said he responded to R6 telling R6 to shut the f*uck up, you f*cking b*tch and also called R6 a fat b*tch.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/31/25 at 1:15 PM, R6 said after hearing R5 throw what sounded like a cup and seeing V9 exit R5's room with water on V9's back, R6 began yelling at R5 to be respectful towards staff and R6 tried explaining to R5 that V9 was not R5's assigned CNA for that shift. R6 said R5 responded by saying, shut up, you f*cking b*tch. Mind your own business, fat ass. R6 said R5 continued to yell at staff, but this was the end of their verbal exchange. R6 said after this verbal altercation with R5, R6 felt frustrated, mad, and was scared that R5 would come into R6's room via R5's wheelchair. R6 requested R6's anxiety medication from V10 (RN) and R6 felt better after the medication administration.</p> <p>On 3/31/25 at 1:52 PM, V10 said after V9 exited R5's room, V10 entered R5's room with V11 (CNA) who responded to R5's needs. V10 said R5 was still verbally aggressive and aggravated. V10 exited R5's room after attending to R5's needs and immediately entered R6's room to assess R6. V10 said that was when R6 requested an anxiety medication from V10 and it was provided. V10 said shortly after the altercation, V10 called V2 and V1 (Administrator) and notified them of the situation.</p> <p>R5 and R6's incident Progress Note dated 3/29/25 shows V10 described the altercation between R5 and R6 as verbal abuse.</p> <p>On 3/31/25 at 2:45 PM, V6 (Nurse Practitioner) said if a resident were to feel threatened or scared, V6 would need to assess the resident and see if there were an overall psychological impact. V6 would ask the resident if they felt safe or if they would like to see other professionals for psychological care.</p> <p>Facility Abuse, Neglect and Exploitation policy dated 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, exploitation and misappropriation of resident property Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47552</p> <p>Based on interview and record review the facility failed to ensure an allegation of resident to resident verbal abuse was immediately reported to the administrator, and reported to the state agency. This applies to 2 of 4 residents (R5 and R6) reviewed for abuse in the sample of 6.</p> <p>The findings include:</p> <p>On 3/31/25 at 1:35 PM, V9 (Certified Nursing Assistant- CNA) said on Saturday, 3/29/25 during V9's shift, R5 got verbally and physically aggressive towards V9 which turned into R5 and R6 engaging in a verbal altercation. This verbal altercation resulted in R5 calling R6 a f*ucking b*tch and a fat b*tch. V9 said after leaving the facility after V9's shift ended, V9 sent V2 (Director of Nursing) a text message informing V2 about the altercation involving V9 and R5. V9 did not notify V2 of the details about R5 and R6.</p> <p>On 3/31/25 at 1:52 PM, V10 (RN) said after talking with and assessing R5 and R6 and providing R6 with anxiety medication, V10 called V1 (Administrator) and V2 and informed them of the incident. V10 did not provide V1 and V2 with all of the specific words that were used between R5 and R6 and just told V1 and V2 that R5 and R6 were shouting at one another.</p> <p>R5 and R6's incident Progress Note dated 3/29/25 shows V10 described the altercation between R5 and R6 as verbal abuse.</p> <p>On 3/31/25 at 10:30 AM, both V1 and V2 said staff did not notify them of the severity of the altercation between R5 and R6 and that the incident was not reported to the state agency yet.</p> <p>On 3/31/25 at 3:31 PM, V1 said V1 is the abuse coordinator and V10 should have notified V1 of all of the specifics regarding the verbal altercation between R5 and R6. V1 said if V10 notified V1 about all of the specifics, V1 would have immediately notified the state agency and conducted an initial investigation. V1 also said if staff are unsure if an incident is considered abuse, staff should provide V1 with all relevant information so V1 can determine whether the incident rises to the level of abuse or not.</p> <p>On 3/31/25 at 2:45 PM, V6 (Nurse Practitioner) said V6 had not been notified by the facility about the verbal incident involving R5 and R6. V6 said if a resident were to feel threatened or scared, V6 would need to assess the resident and see if there were an overall psychological impact. V6 would ask the resident if they felt safe or if they would like to see other professionals for psychological care.</p> <p>Facility provided email receipt to the state agency shows the initial incident report wasn't provided to the state agency until 3/31/25.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Abuse, Neglect and Exploitation policy dated 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, exploitation and misappropriation of resident property Reporting/Response . 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>