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	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Hlthcr of Woodstock	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)
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** 40798 Based on interview and record review, the facility failed to ensure residents were free of mental abuse for 2 of 3 residents (R1 and R2) reviewed for abuse in the sample of 3. This failure resulted in R1 suffering undue, ongoing anxiety and contributed to his leaving the facility and made R2 feel badly. The findings include: On 4/29/25 at 10:17 AM, R1 said he has lived in the facility for over two years but is transferring to another facility later today due to the abusive environment. R1 said on one particular Sunday, V3, Regional Director of Operations/Former Administrator, came into the facility, rounded up all of the staff and lined them up in the hall. R1 said V3 began to walk up and down the line of employees yelling at them and pointing his finger at them. R1 said V3 was reprimanding these adults, these professionals and it was terrible, demeaning, and unprofessional. R1 said he felt upset and intimidated. R1 said the incident upset him immensely, and he was totally and completely stressed out. R1 said V3 had no regard for the feelings of anyone else who was around or witnessed the incident. R1 said during this interview, he became so anxious just talking about it, he had to turn up his oxygen. On 4/29/25 at 11:19 AM, R2 said V3 saw some unmade beds and he lined the Certified Nursing Assistants (CNAs) up in the hallway and yelled at them like a drill sergeant. R2 said it made him feel horrible when V3 would reprimand staff in front of everyone, it is inhumane. On 4/29/25 at 9:58 AM, V4, Licensed Practical Nurse (LPN), said she remembers a weekend when V3 came in and said they were having an in-service. V4 said V3 lined up all the nurses and CNAs in the hallway and was yelling at them. V4 said there were residents around and they were concerned as to why they were all in trouble. V4 said she doesn't remember exactly what was said during this incident because there have been many interactions like that. V4 said R1 asked what it was all about, but V4 said she felt it was pretty evident and the whole incident speaks for itself. V4 said R1 was upset about the incident and how V3 approached things. V4 said V3 would call staff out right in front of everyone and a lot of residents are on edge about how things are handled by V3. V4 said V3 leads with fear. V4 said R1 is transferring to another facility today because of V3's management of the facility. (continued on next page)

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

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	04/30/2025

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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	On 4/29/25 at 12:21 PM, V5, LPN, said on a Sunday, 12/1/24 around 10:30 AM, V3 had all the staff lined up in the hall out in front of the dining room. V5 said V3 called it an in-service, but he just started talking down to the staff like they were children. V5 said there were residents present during this incident. V5 said she reached out to one of the managers to look at the cameras because of this incident. V5 said V3 is very authoritative and does not like it when any staff say anything to him. On 4/29/25 at 1:55 PM, V3 said he would conduct in-services with all the staff lined up in the hall and residents could be present and overhear them. V3 said types of abuse include emotional and psychological abuse. On 4/30/25 at 9:40 AM, V9, Business office Manager, said she had a good rapport with R1, and he told her he had seen V3 line up staff members and go down the line one by one yelling at them. V9 said R1 chose to transfer to another facility due to incidences happening with staff over the course of his stay. V9 said R1 was one of the most beloved residents in the facility by staff and other residents. V9 expressed fear of losing her job if management found out what she has reported during this interview. R1's Admission Record dated 4/30/25 shows he was admitted to the facility on [DATE]. R1's diagnoses include, but are not limited to, panic disorder (episodic paroxysmal anxiety) and adjustment disorder with mixed anxiety and depressed mood. R1's Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively intact and has no behaviors. R1's current care plan provided by the facility shows R1 demonstrates significant mood distress related to recent medical conditions and previous trauma. R1 has potential for anxiety related to traumatic life event. Interventions include establishing trust with the resident and providing a calming and reassuring environment to help lessen or relieve anxiety and promote a feeling of safety. R2's Admission Record dated 4/30/25 shows R2 was admitted to the facility on [DATE]. R2's diagnoses include, but are not limited to, personality disorder, dysthymic disorder, bipolar disorder, and generalized anxiety disorder. R2's Minimum Data Set, dated dated dated [DATE] shows R2 is cognitively intact and has no behavioral symptoms or behaviors which are potential indicators of psychosis. R2's current care plan provided by the facility shows R2 has a mental disorder and interventions to help R2 maintain the highest practicable physical, mental, and psychosocial well being are to provide an environment and atmosphere that is conducive to mental and psychosocial well-being. R2 has potential for anxiety related to traumatic life event. Interventions include establishing trust with the resident and providing a calming and reassuring environment to help lessen or relieve anxiety and promote a feeling of safety. The facility's Abuse, Neglect, and Exploitation Policy (revised 11/2024) shows the facility will provide protection for the health, welfare, and rights of each resident by implementing procedures that prevent abuse. The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities booklet (Revised 11/18) shows residents must not be mentally abused by anyone.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47552 Based on interview and record review the facility failed to ensure an incident of verbal abuse was reported to the state agency. This applies to 2 of 3 residents (R1000, R1001) reviewed for abuse in the sample of 3. The findings include: On 6/11/25 at 9:25 AM, V2 (Director of Nursing) said on the morning of 6/9/25, R1001 was being assisted back to R1001's room when R1001 became verbally aggressive, shouting at staff using foul language and using racial slurs. V2 said as R1001 passed R1000's doorway, R1001 and R1000 exchanged words leading to R1001 calling R1000 a fat*ss and R1001 was being nasty towards R1000. V2 said the incident was not reported to the state agency and she felt the incident was more of a verbal altercation and not verbal abuse. On 6/11/25 at 1:15 PM, V1 (Administrator) said he was initially unaware of the altercation on 6/9/25 between R1000 and R1001 and believed the incident talked about with V2 at 9:25 AM was a previous incident. V1 also talked with R1000 about the incident and said that R1000 did believe the incident was verbally abusive and not just a verbal altercation. Facility Abuse, Neglect, and Exploitation policy dated 11/2024 states, . 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 .