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	07/14/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's funds were safeguarded and free from misappropriation. This applies to 2 of 3 residents (R4, R5) reviewed for misappropriation in the sample of 5. The findings include:(1.) R4's Minimum Data Set (MDS) dated [DATE], shows that R4 is cognitively intact.On 7/14/25 at 9:06 AM, R4's bedside drawer had a latch attached, allowing the top drawer to be locked by a pad lock. There was not a pad lock on the drawer at this time. The back panel of R4's bedside drawer was originally fastened with nails. However, at this time, the back panel of R4's bedside drawer was still half off, allowing access into R4's bedside drawer through the back. On 7/14/25 at 9:06 AM, R4 said after returning from a day out on pass with family on a Saturday in June, R4 noticed that R4's bedside drawer had been pulled away from the wall and a plastic shoebox containing compact discs and a compact disc player was on the floor behind the bedside drawer. R4 thought nothing of it that evening and asked staff to help pick up the items and move the bedside drawer back to the wall. The next morning, R4 noticed that the bag where R4 keeps R4's money in the top, locked drawer had been ripped in half and all of R4's money, except for approximately $25 in bills, was gone. R4 said there was approximately between $200 and $300 in the bag. R4 spoke with V10 (Social Services Director), V13 (Business Office Manager), and V1 (Administrator) about the incident the Monday after it happened and R4 requested the facility not to contact the local police or R4's husband. R4 said she doesn't exactly recall when the money could have been taken but indicated that whoever took it knew that R4 likes to sit outside while at the facility and that R4 had left the faciity on 6/21/25 to visit family. R4 typically carries R4's key to the lock in R4's purse, which is on R4 at all times. R4 said approximately three years prior, R4 had two separate instances where someone took money from R4's purse while R4 was sleeping. Ever since then, R4 had requested and been locking away R4's money in the top drawer of R4's bedside drawers using a padlock to keep it locked. R4 said only a handful of employees at the facility knew R4 had money in the top drawer. R4's Resident Sign In/Out Sheet shows that R4 signed out of the facility on 6/21/25 at 12:00 PM and returned the same day at 7:44 PM. R4's Progress Note dated 6/23/25, written by V10 (Social Services Director) states R4 informed V10 of the missing money and that V1 (Administrator) was made aware. On 7/14/25 at 11:02 AM, V13 (Business Office Manager) said she started working at the facility on January 27th, 2025. Since V13 has worked at the facility, V13 has known R4 to always keep R4's money in the top drawer of R4's bedside drawers, locked with a lock and key. V13 said R4's husband gives R4 spending money once a month and R4 keeps the money in the locked top drawer. V13 also corroborated that multiple certified nursing assistants knew where R4 kept R4's money. After the incident, V13 spoke with R4 who entrusted R4 to hold onto the remaining money as well as all of the loose change that was in R4's top drawer. On 7/14/25 at 10:26 AM, V1 said it's difficult to remove the back panel of the bedside drawer and whoever did it must have had a tool to remove the back. (2.) R5's MDS dated [DATE], shows R5 is cognitively intact.On 7/14/25 at 9:50 AM, R5 was unable to recall when it happened, but R5 told staff that R5's wallet with approximately $45 had gone missing from R5's room. R5 last saw R5's wallet in the top drawer of R5's bedside drawer. R5 saidV11 (R5's Family Member) gives R5 money every month and R5 would keep that money in the wallet in the bedside drawers. R5's Progress Note dated 6/23/25, written by V10 shows that R5 told V10 about the missing money and wallet. On 7/14/25 at 12:37 PM, V11 confirmed that V11 would give R5 approximately $25 to $30 every month and R5 would keep the money in the wallet in the bedside drawer. V11 said the facility indicated that it was believed the wallet and money were stolen based upon it happening around the same time that R4's money was found to be taken. 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 . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

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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. Based on interview and record review the facility failed to report an allegation of abuse to the state agency. This applies to 3 of 3 residents (R1, R4, R5) reviewed for abuse in the sample of 5. The findings include:(1.) On 7/14/25 at 12:00 PM, R1 said approximately three months ago, R1 lost his wallet in the facility. R1 stated the facility found the wallet in laundry, but when it was returned, R1 noticed there was a $100 bill missing from inside the wallet. Nothing else was removed or misplaced from R1's wallet. R1 said everybody knew the money was missing, including V10 (Social Services Director). R4 requested the facility to not contact the local police or R4's husband regarding the missing money.On 7/14/25 at 1:38 PM, V1 (Administrator) said he believes the incident regarding R1's lost money and wallet happened prior to V1 started working at the facility in April. V1 said V1 heard about the incident a few weeks ago when V1 heard staff talking about the incident in the hallway. V1 states he spoke with R1 and laundry employees, but V1 never completed a formal investigation and never, himself, sent a report to the state agency, believing that it had already been done. V1 never confirmed whether the allegation had been reported to the state agency.(2.) On 7/14/25 at 9:06 AM, R4 said a few weeks ago, towards the end of June, R4 left the facility to go out on pass to visit family on a Saturday at around noon. R4 returned to the facility on the same day at approximately 8:00 PM. When R4 returned, R4 noticed R4's bedside drawer pulled out from the wall and a plastic shoe box containing compact discs and a compact disc player was on the ground, behind R4's bedside drawer. R4 had staff pick up the items from the ground and push the bedside drawer back. When R4 looked into the locked top drawer, R4 noticed the bag that R4 keeps R4's money in was torn in half, R4's money was missing except for approximately $25, and R4 noticed the back of the bedside drawer had been removed to access the locked top drawer. R4 told facility staff the following Monday morning, including V1, V10, and V13 (Business Office Manager). On 7/14/25 at 10:26 AM, V2 (Director of Nursing) and V1 said there were a couple residents who complained of missing money recently, including R4 and R5. V1 said V10 wrote everything about the incident into R4's electronic medical records.(3.) On 7/14/25 at 9:50 AM, R5 could not recall when, but stated some time in June, R5 noticed R5's wallet with money (approximately $45) went missing from the top drawer of R5's bedside drawer. R5 said the drawer was not locked, but nobody knew it was there. R5 told V1 and other staff about the missing money. R5 also stated that the police were never called for this incident.On 7/14/25 at 10:26 AM, V2 (Director of Nursing) said V2 has not sent any reports to the state agency regarding missing money since 6/12/25.As of 7/14/25, the facility was unable to provide documentation showing R1, R4, and R5's allegations of missing money had been reported to the state agency.On 7/14/25 at 1:38 PM, V1 said V1 told corporate that even if as little as 50 cents gets reported missing to V1, V1 will be sending a report to the state agency from now on.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 . 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 .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to ensure allegations of misappropriation were thoroughly investigated. This applies to 3 of 3 residents (R1, R4, R5) reviewed for abuse in the sample of 5. The findings include:(1.) On 7/14/25 at 12:00 PM, R1 said approximately three months ago, R1 lost R1's wallet. R1 said it was later found in the laundry and was returned to R1, but was missing a $100 bill. R1 notified staff of the missing money, but R1 said R1 has not been reimbursed for the missing money. Facility resident council minutes for April 2025 shows that a resident mentioned they were missing money during laundry. The resident council minutes also show that R1 was in attendance for the April meeting. (2.) On 7/14/25 at 9:06 AM, R4 said after returning from a day out on pass with family on a Saturday in June, R4 noticed that R4's bedside drawer had been pulled away from the wall and a plastic shoebox containing compact discs and a compact disc player was on the floor behind the bedside drawer. R4 thought nothing of it that evening and asked staff to help pick up the items and move the bedside drawer back to the wall. The next morning, R4 noticed that the bag where R4 keeps R4's money in the top, locked drawer had been ripped in half and all of R4's money, except for approximately $25 in bills, was gone. R4 said there was approximately between $200 and $300 in the bag. R4 spoke with V10 (Social Services Director), V13 (Business Office Manager), and V1 (Administrator) about the incident the Monday after it happened and R4 requested the facility not to contact the local police or R4's husband. R4's progress note dated 6/23/25, written by V10, shows V10 gathered preliminary information from R4, spoke with the local ombudsman, and reviewed a portion of the cameras.On 7/14/25 at 10:26 AM, V1 said all the information regarding the investigation for R4's incident was written as a progress note in the electronic medical records. On 7/14/25 at 10:40 AM, V10 said she only spoke to a few employees that had worked on Saturday, 6/21/25, but V10 did not retain copies or documentation of the interviews. The only documentation V10 completed was the progress note in the electronic medical records. V10 was unsure if V1 had conducted any interviews or conducted an investigation. (3.) On 7/14/25 at 9:50 AM, R5 said R5 could not recall exactly when, but R5 told staff that R5's wallet containing approximately $45 was taken from the top drawer of R5's bedside drawer. R5 said the drawer was not locked. R5 also said the local police were never contacted regarding the incident. R5's progress note dated 6/23/25, written by V10, shows V10 searched R5's room for the missing wallet and money, but the items were not found. There are no indications that V10 had conducted an investigation. On 7/14/25 at 10:26 AM, V2 (Director of Nursing) and V1 said the only documentation regarding investigations for R4 and R5's missing items were written by V10 into the electronic medical records. As of 7/14/25, the facility was unable to provide further documentation showing the facility completed and/or conducted investigations into any of the three allegations for R1, R4, and R5. Facility Abuse, Neglect, and Exploitation policy dated 11/2024 states, . A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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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. Based on observation, interview and record review the facility failed to ensure a resident was transferred safely using a mechanical lift for 1 of 3 residents (R1) reviewed for safety in the sample of 5.The findings include:On 7/14/25 at 10:05 AM, R1 was sitting in his wheelchair in the dining room. R1 had a raised discolored area on his right posterior forearm. R1 said that he had a fall while being transferred from his bed to the wheelchair with a mechanical lift. R1 said that there was only one aide in the room when he fell. R1 said that the lift tipped over and landed on the aide. R1 said that he went to the hospital right afterwards and got an X-ray of his right arm and a scan of his head. R1's Nurse Practitioner Note dated 7/1/25 at 11:40 AM shows, Patient seen and examined today per nursing request for a witnessed fall. Per CNA (Certified Nursing Assistant), patient being lifted by Hoyer (mechanical) lift then sling tipped to the side and patient fell on the floor. DON (Director of Nursing) reports patient had loss of consciousness and awoke only after stimuli, shaking patient. 911 called. Upon arrival in the room, observed patient in right side-lying position on the floor w/ head supported by a pillow towards the door threshold.On 7/14/25 at 11:27 AM, V3, Certified Nursing Assistant (CNA) said that she was transferring R1 from his bed to the wheelchair when the mechanical lift tipped over and fell. V3 said that she was doing the transfer by herself because they were busy that day. V3 said that she attached R1's sling to the lift and lifted him from the bed. V3 said that as she was pulling him away from the bed, the lift legs got stuck and the lift began to tip. V3 said that when the lift tipped over, she ended up underneath R1. On 7/14/25 at 2:06 PM, V4 (Licensed Practical Nurse) said that she was doing medication pass in the hallway when she heard a loud clatter, so she rushed down the hall to find the source. V4 said that she went by R1's room and saw R1, the mechanical lift, and the CNA on the floor. V4 said that R1's head was in the doorway and his feet were towards the bed. V4 said that he was not near his bed at all, he was in the middle of the room and the mechanical lift legs were parallel to the bed. V4 said that the only staff member in the room was V3 and she was under R1 by his head. V4 said that V3 did not come and ask her for help with the transfer.On 7/14/25 at 2:27 PM, V2 (Director of Nursing) said that she responded to the incident with R1 on 7/1/25. V2 said that when she went into the room, R1 was laying on the floor on his right side. V2 said that his pulse oximetry was reading 59% and for a moment he was unresponsive. V2 said that the nurse practitioner came and assessed him right away and they decided to send him out to the hospital for an evaluation due to his unresponsiveness and low oxygen saturation. V2 said that after the fall she did an investigation into what happened. V2 said that V3 told her that she was the only CNA in the room when the mechanical lift tipped over. V2 said that mechanical lift transfers should always be done with two staff members for the resident's safety. V2 said that V3 also felt that the mechanical lift was broken. V2 said that the lift was a rented bariatric lift. V2 said that she looked at the lift and found that the boom of the lift was wobbly so she had removed it from the facility and had the rental company come pick it up. R1's Electronic Health Record shows that he weighed 324 pounds on 6/3/25. R1's Hospital After Visit Summary dated 7/1/25 shows diagnoses of: contusion of right forearm and head injury. R1's Kardex as of 7/14/25 does not document his transfer status.The facility's Safe Resident Handling/Transfers Policy revised on 10/2024 shows, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident.Two staff members must be utilized when transferring residents with a mechanical lift.