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	07/28/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review the facility failed to have evidence that R4's alleged allegations were thoroughly investigated for 1 of 6 residents (R4) reviewed for abuse in the sample of 6. The findings include:On 07/23/2025 at 12:22PM, R4 was lying in bed on his left side with eyes closed. On 07/23/2025 at 12:22PM, R4 said, the staff have been giving me a hard time when I call for help. I went to the bathroom; the staff gave me a hard time due to them getting off work soon. I told the administrator. V5 CNA's-Certified Nursing Assistant told me she did not want to come in my room to provide care. I told her to shut her mouth. She started walking down the hallway cussing. I watch the security video with the administrator yesterday. It showed V5 CNA walking down the hallway. The video did not have sound at the time, V1 may not have turned the volume on.On 07/23/2025 at 12:30PM, V1 Administrator was not in the facility.On 07/28/2025 at 8:37AM, V1 Administrator said, I will call you back. On 07/28/2025 at 11:19AM, V4 Nurse Consultant said, V1 Administrator has been removed from his position; I attempted to obtain information about R4 and V5 CNA from V1 last Wednesday (07/23/25) after I was told about the incident. On 07/23/25 and on 07/28/25 The facility was not able to provide documentation or verbal confirmation to show R4's allegation of verbal abuse was investigated.V5 CNA was not available at the time of the survey. The facility's Abuse Policy dated 11/2024 shows, 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. Alleged Violation is a situation or occurrence that is observed or reported by . resident .but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements .Written procedures for investigations include . Providing complete and thorough documentation of the investigation.

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	07/28/2025

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 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** Based on observation, interview, and record review the facility failed to ensure R1 did not leave the facility unsupervised, this applies to 1 of 6 residents (R1) reviewed for supervision in the sample of 6.The findings include: R1'S Minimum Data Set, dated [DATE] shows, R1 has a moderate cognitive impairment. On 07/23/2025 at 9:00AM, R1 was lying in bed. R1 sat up on the side of the bed. R1 then moved her wheelchair into position, engaged the left and right brake, stood to her feet, and sat herself down in the wheelchair. On 07/23/2025 at 9:00AM, R1 said, I can move myself in my wheelchair using my arms and legs. I am not able to move quickly. On 07/23/2025 at 11:30AM, V4 Nurse Consultant said, after R1 was found outside we initiated 1:1 monitoring and then applied a bracelet to her arm. When R1 gets close to the doors that lead outside an alarm will go off. On 07/23/2025 at 12:53PM, V2 DON-Director of Nursing said, the front door alarm went off around 9:30PM. There is no receptionist at the front door during that time. R1 went outside alone.On 7/23/2025 at 1:15PM, V3 CNA-Certified Nursing Assistant said, it was not the door alarm that alerted the staff. There was a visitor that recognized R1 should not be outside the building at night. The staff heard the visitor ringing the doorbell, that is when they found R1 outside the facility.V6 CNA's written statement dated 07/18/25 at 9:30PM, shows, the doorbell was rang by a concerned citizen that a patient was outside. I told one of the patients to get the nurse and I went outside to bring the patient back in.V6 CNA was not available for comment during the survey. R1's Elopement Investigation Timeline dated 07/18/2025 shows, at 9:22PM, R1was wearing a night gown and carrying a bag of belongings. At 9:23PM, R1 exited the facility. At 9:30PM, a visitor rang the doorbell. At 9:34PM, R1 was brought back inside the facility by V6 CNA.