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	08/06/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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	08/06/2025

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 0604 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 observation, interview, and record review, the facility failed to ensure a resident (R11) was free from restraints. This applies to 1 of 1 resident's reviewed for restraints in the sample of 11.The findings include:R11's electronic face sheet printed on 8/6/25 showed R11 has diagnoses including but not limited to chronic respiratory failure, heart failure, history of falls, bipolar disorder, and unsteadiness on feet.R11's facility assessment dated [DATE] showed R11 has moderate cognitive impairment and does not utilize restraints.On 8/6/25 at 12:15PM, V12 (Licensed Practical Nurse) assisted R11 into his bed and put the half side rail down on the left side of the bed. (The bed rail is positioned so it covers the middle of the bed and R11's bed is pushed against the wall on the right side).On 8/6/25 at 12:17PM, V13 (Certified Nursing Assistant) stated, We always put the siderail down for (R11) to help with positioning and so he knows to ask for help to get up. If he did try to get up, he would have to scoot all the way to the end of the bed to try and get up because of how the rail is on his bed.On 8/6/25 at 2:00PM, V14 (Minimum Data Set Nurse-MDS) stated, I do the restorative MDS for the GG section and the 3 assessments that go with it (Functional ability, bowel and bladder, and the side rail assessment). (R11) does have 1/2 side rails on each side of his bed. I assessed him for side rails for bed mobility-not for restraints. He can't put them down independently to sit on the edge of the bed. I didn't have any training on restorative nursing; I just watched someone else do it at my old building. I'm not technically the restorative nurse; I just do the assessments and MDS for restorative. We don't have a restorative nurse. Surveyor then accompanied V14 to R11's room to observe side rail positioning. V14 stated, The way that (R11's) rail is right now in the down position, it is a restraint because he cannot get out of the bed on either side of the bed. V14 also stated that R11 would have to climb over the rail or scoot to the edge of the bed to get out which would pose a risk for harm.On 8/6/25 2:23PM, V3 (Director of Nursing) stated, (R11) does self-transfers from the chair to the bed but he never wants to get out of bed so it wouldn't really be an issue for his bed rail to be down. He could technically scoot all the way to the end of the bed and go around the rail, but I guess that wouldn't be the safest option. He would never try to climb over the rail so that's not a realistic scenario with him. I think with his rails they are supposed to be kept up so that he can use them for positioning. He normally lays on his back, but he will occasionally use them just to get off his back for a few seconds. He should have a physician's order for the rails and there should be documentation of anything we have tried previously but his aren't used for falls, they are for mobility. (R11's physician's order showed no order for R11 to utilize side rails for bed mobility or positioning).The facility's policy titled, Proper Use of Bed Rails dated 8/2024 showed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensure correct installation, use, and maintenance of the rails .5. The facility will assess to determine if the bed rail meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. The facility's policy titled, Restraint Policy dated 3/2025 showed, Physical Restrain refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to .Using bed rails to keep the resident from voluntarily getting out of bed .

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	08/06/2025

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. (continued on next page)

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	08/06/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 residents (R8,R11) had fall prevention measures in place. This applies to 2 of 3 resident's reviewed for fall prevention in the sample of 11.The findings include:1) R8's electronic face sheet printed on 8/6/25 showed R8 has diagnoses including but not limited to metabolic encephalopathy, schizoaffective disorder, anxiety disorder, restlessness and agitation, and major depressive disorder.R8's facility assessment dated [DATE] showed R8 has severe cognitive impairment, has not had any falls since admission to the facility, and does not utilize alarms while in her bed or chair.R8's fall risk assessment dated [DATE] showed R8 is a high fall risk.The facility's Incident Report Log as of 8/5/25 showed R8 has experienced 11 falls within the past 3 months at the facility.On 8/5/25 at 12:53PM, R8 was in her bed laying on her right-side sleeping. R8's alarm clip was hanging on the mattress next to her bed on the floor and was not clipped to R8. V12 (Licensed Practical Nurse) stated, (R8) is a very high fall risk. She needs the mattress next to her bed at all times and she also has orders for a bed and chair alarm. When she is in bed, she has a pressure pad alarm and when she is up in her chair she uses the clip alarm. (V12 confirmed R8 has orders for both alarms). V12 went into R8's room with surveyor and confirmed R8 did not have the alarm clipped to her nor did she have a pressure pad alarm underneath her. V12 stated, It's not beneficial if the clip isn't connected because it won't alert staff that she's trying to get up. During the same observation, R8's call light was draped over the back of the head of her bed where R8 was unable to reach it. V12 stated R8 rarely uses her call light but she should have it available in case she needs something.On 8/6/25 at 2:23PM, V3 (Director of Nursing) stated, I was informed before dinner yesterday that (R8) has apparently been removing her clip alarm on her own. We switched her over to a pressure alarm last night so that she can't unclip her alarm, but she will probably just pull this one out from under her. I don't know how else to prevent falls for her. If there is an order for staff to be putting a clip alarm on, then that's what they should have been doing but I'm pretty sure she took it off herself. (Surveyor was unable to find any documentation relating to R8 removing her clip alarm aside from an 8/5/25 entry after surveyor observed R8 in bed without the alarm clipped on her and staff were interviewed).The facility's policy titled, Fall Risk assessment dated 08/2025 showed, It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents .5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice .2) R11's electronic face sheet printed on 8/6/25 showed R11 has diagnoses including but not limited to chronic respiratory failure, heart failure, unsteadiness on feet, and history of falls.R11's facility assessment dated [DATE] showed R11 has moderate cognitive impairment and does not utilize alarms or bed rails.R11's care plan revised on 10/11/23 showed, (R11) is at risk for falls related to dementia and limited physical mobility .bed alarm placed on bed, floor mat next to bed .R11's physician's orders dated 1/30/23 showed, Bed alarm placement.On 8/6/25 at 12:12PM, V12 was in R11's room and told him she would have staff assist him to bed. Surveyor observed R11 transfer himself to his bed without staff assistance. V12 went back into R11's room, assisted him to lay down, put his side rail down, and left the room. Surveyor went into R11's room, visualized his pressure alarm on his bed and the alarm box was not blinking indicating the alarm was functioning. On 8/6/25 at 12:17PM, V13 (Certified Nursing Assistant) stated, (R11) doesn't use a bed alarm. His bed alarm must be as needed. The nurse didn't tell us if he needed it. I don't even really know him that well so can't tell you much. Surveyor went into R11's room with V13 who verified that R11's bed alarm was not turned on or functioning). V13 stated, All residents that are at risk for falls should have their preventative measures in place at all times to hopefully prevent them from falling.On 8/6/25 at 2:10PM, V12 stated, According to (R11's) orders, he does use a bed alarm, but I didn't know that. Surveyor went into R11's room with V12 who confirmed R11's bed alarm was not on and turned it on in front of surveyor. The bed alarm then beeped which V12 indicated that meant the alarm has been turned on and was blinking to show functionality.On 8/6/25 at 2:23PM, V3 (Director of Nursing) stated, I don't think (R11) uses an alarm at all. I guess if he has an order he should have had it on to prevent falls, but I don't think he is a high fall risk. He hasn't had a fall recently, but I know he self-transfers from the chair to the bed which I suppose could put him at risk for falls if he isn't supposed to be doing it alone.The facility's policy titled, Fall Prevention Program dated 11/2024 showed, Each resident will be assessed for fall risk and will receive care and services in