STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Healthcare of Rochelle	1021 Caron Road Rochelle, IL 61068

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 - Minimal harm or potential for 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. 20042 Based on interview and record review the facility failed to protect a resident from mental abuse for one of four residents (R1) reviewed for abuse in the sample of 7. The findings include: The Face Sheet dated 1/22/25 for R1 showed diagnoses including major depressive disorder, anxiety disorder, autistic disorder, bipolar disorder, vitamin D deficiency, hyperlipidemia, hypothyroidism, and obesity. The Facility Incident Report Form - Final Report dated 1/13/25 showed, on 1/13/25, a nurse was notified by R1 that V4 CNA (Certified Nursing Assistant) and V5 CNA made her feel bad for two weeks. R1 stated she was ill a couple weeks ago, and V4 and V5 made her pick up the bedding after she became sick on the sheets. R1 stated, I had to clean up the vomit on the sheets, wall, and floor. Both CNAs told me I was on an independent hall and had to clean up after myself. Staff members involved were placed on suspension pending investigation. An investigation was immediately initiated. R1 was assessed head to toe and did not show any signs of obvious signs of physical, mental, or psychosocial distress or complaints of pain. No complaints of pain or mental anguish noted. All residents were interviewed by the administrator. Staff in the last 72 hours of the allegation were interviewed by the Director of Nursing. Per the interviews, there is a substantiated allegation of mental abuse. On 1/22/25 at 9:20 AM, R1 stated on 1/2/25 she threw up and V4 CNA and V5 CNA were bullying her. R1 stated V4 and V5 told her that if she couldn't clean up her own vomit then she can't be on the independent hall for residents. R1 stated V4 and V5 made her clean up her own vomit. R1 stated she did not tell anyone right away. R1 stated what V4 and V5 was doing was rude. R1 stated it made her fell upset, uncomfortable, and angry. R1 stated she was really frustrated when this happened. R1 stated V1 (Administrator) fired V4 and V5 and she felt better about it because it relieved her anxiety. (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: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 Caron Road Rochelle, IL 61068	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 10:00 AM, V1 (Administrator) stated, R1 came to them the day V1 made the report to state. R1 said 2-3 weeks ago she was getting sick; R1 had the norovirus. R1 put her call light on, V4 and V5 came to her room to assist her and made R1 feel bad because she had thrown up on the bed, floor, and wall. R1 said she cleaned it up. R7 (R1's roommate) said she wasn't sure who cleaned it up but it was not cleaned up too well, so she believed it was R1 that cleaned it up herself. V1 stated she looked into it; she did an investigation. V4 and V5 were suspended right away. Interviews were completed with residents and the staff. V1 stated based on R1's interview and her BIMS (Brief Interview of Mental Status) score being 15 (cognitively intact), they terminated the employees and found it as abuse. V1 stated V5 did not say a whole lot when he was interviewed. V4 stated she cleaned it up and R1 kept puking on the floor while V4 was cleaning. V4 said she told R1 to go to the bathroom to throw up and R1 finally did. On 1/22/25 at 11:01 AM, V8 (Social Services) stated R7 (R1's roommate) came into the office that she (V8) shares with V2 DON (Director of Nursing) and stated staff came into their room one day when R1 was sick; R1 had puked. The staff talked to R1 in a rude manner and R7 felt it was verbal abuse. V8 stated that she and V2 told V1 what R7 said and V1 started an investigation. V8 stated she talked to R1 and R7 separately and put a note in each of their electronic medical records. V8 stated after she talked to R1 she felt that what R1 stated was credible. V8 stated R1 is withdrawn and anxious at times. V8 stated she asked R1 why she did not tell anyone about it and R1 stated she was worried and anxious about telling what happened. On 1/22/25 at 11:53 AM, R7 stated she heard what was going on with R1 and did not see anything because her curtain was closed. R7 stated R1 threw up so R7 put the call light on. A male and female CNA came into the room. The female CNA said, Why did you throw up in the bed? and Why didn't you go to the bathroom? The female CNA told R1 she could have used the waste can and was picking at R1 who told them that it just happened so fast. R7 sated the CNAs told R1 that she had to clean it up. A couple days later V12 (Housekeeping/Laundry Manager) came by and there was still vomit on the bed so he re-cleaned it. R7 stated the CNAs were rude and nasty. No one needs to be treated that way. There was a whole house full of people sick at that time. R7 stated she was disgusted by it. R7 stated to be treated like sh*t was not okay. R7 stated she went and reported it because what happened was just not right. R7 stated V4 and V5 were the CNAs. R7 stated V4 did the talking. V5 never said anything but he didn't stop it either. On 1/22/25 at 12:31 PM, V4 CNA stated everyone was on isolation and R1 kept coming out of her room, throwing up in a garbage can in front of everyone. R1 threw up all over her bed, garbage can and floor. V4 stated R1 was throwing up while V4 was trying to clean it up. V4 stated she cleaned everything up but R1 claims that she did it. V4 stated V5 was with her. On 1/22/25 at 1:18 PM, V10 RN (Registered Nurse) stated she was R1's nurse on 1/2/25 and R1 had norovirus at that time. V10 stated R1 vomited all over because she did not get to the bathroom in time. R1 made a remark to V4 and V5 that they should clean it up. V10 stated the only thing she heard V4 say was if R1 knew she was nauseated and had to throw up then why not go to the bathroom. R1 said she wanted to wait because she was on her phone. V10 stated that was the only communication she heard. V10 stated R1 never said anything to her about it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1:48 PM, V11 RN stated she did not know anything about the incident until she came into work, and 1 week later another resident, not R1, told V1 (Administrator) about it. R7 (R1's roommate) told V8 (Social Services) what happened. V11 stated the incident was already investigated by the time she heard about it. V11 stated it is not okay to yell at residents; this is their home. V11 stated R1 has autism and doesn't know how to process her feelings very well, R1 deserves to feel safe. The facility's Abuse Investigation employee interview form dated 1/13/25 (no time) for V6 RN documents V4 has been heard yelling at residents and gave the example of V4 telling residents to go back to their rooms. V7 RN's statement on 1/13/25 (no time) documents R1 reported to the nurse that V4 and V5 had hurt her feelings. V4 and V5 made R1 clean her own bed soaked with vomit. V4 and V5 went on to tell R1 she couldn't be on the independent hall because R1 is unable to care for herself. The facility's Abuse, Neglect and Exploitation policy (11/2024) showed, Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or metal anguish, which could include staff to resident abuse and certain resident to resident altercations. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The facility will provide ongoing oversight and supervision of staff in order to assure that it's policies are implemented as written. 0