STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010136	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLIGHT HLTHCR OF WOODSTOCK	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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S 000	Initial Comments Complaint Investigation 2513709/IL191032	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidence by: 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	S9999		

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S9999	Continued From page 1	S9999		

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

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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.

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

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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 1/17/23. 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 2/14/25 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 9/7/22. 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 2/18/25 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

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S9999	Continued From page 4 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. (B)	S9999		