STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058347	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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

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S0000	Initial Comments First Certification Revisit to Survey 04/30/2025, Complaint Investigation 2513709/IL191032	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 personal care needs of the resident. 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 Regulations are not met as evidenced by: Based on interview and record review the facility failed to ensure one resident (R1000) was free from verbal abuse by another resident (R1001). This failure resulted in R1000 experiencing anxiety, which required the use of medication to alleviate the anxiousness caused by the verbal abuse. This applies to 2 of 3 residents (R1000, R1001) reviewed for abuse in the sample of 3. The findings include: R1000s Face sheet dated 6/11/25 shows R1000 has diagnoses that include but are not limited to; adjustment disorder with mixed anxiety and depressed mood, other specified depressive episodes, and need for assistance with personal care. R1000s Care Plan focus initiated on 3/31/25 shows R1000 "... demonstrates behavioral distress related to: dx (diagnoses) of depression and anxiety. Problems are manifested by: Expresses feelings of being verbally abused by another resident. R1001's Care Plan focus initiated on 3/31/25 shows "This resident is/has potential to be verbally aggressive, shouting at staff and other residents' r/t (related to) ineffective coping skills." R1001's Progress Note dated 6/4/25 shows R1001 became verbally aggressive with staff. R1001's Progress Note dated 6/6/25 shows R1001 became verbally aggressive with staff again.	S9999		

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S9999	Continued from page 2 On 6/11/25 at 8:55 AM, R1000 said on the morning of 6/9/25, she heard R1001 yelling towards staff by what she believed was the 100/200-unit nurse's station. R1000 said a staff member, later identified as V7 (Certified Nursing Assistant-CNA), assisted R1001 back to his room in his wheelchair. When R1001 and V7 passed R1000's room, R1000 asked R1001 to please stop yelling towards staff. R1000 said R1001 responded by saying, "shut your f***ing mouth you fat*ss." She said R1001 then continued yelling towards her using foul language and she asked R1001 to stop saying her name. R1001 responded to her request by saying, "shut up you f***ing b*tch." R1000 said after the incident, staff checked on her and provided her with an anti-anxiety medication. R1000 said after 30 minutes of receiving the anti-anxiety medication, she was finally calm. On 6/11/25 at 1:36 PM, V7 said she is fairly new to the facility and has only been working there for approximately two weeks. V7 said on the morning of 6/9/25, R1001 requested V7 to assist him to the shower room. V7 said when R1001 was exiting the shower room, he dropped a shampoo bottle, and it spilled on the floor. V7 said R1001 was already visibly upset at this time and asked her to assist him back to his room. Before helping, V2 (Director of Nursing) told R1001 that she had a package for him. V7 said R1001 became more upset after this comment, and he responded to V2 saying that the package was supposed to arrive a few days earlier and that V2 can keep the box. As V7 continued to assist R1001 towards the room, R1001 held his feet in the air, not assisting her propel his wheelchair down the hallway. V8 (CNA) was down the 100 hall and saw R1001 not using his feet to assist V7 and told V7 to have R1001 help propel his wheelchair down the hallway because he is able to help. V7 said when R1001 heard that comment, he responded to the staff member to "go to hell" and to "f**k off". V7 said R1001 continued using foul language and yelling towards staff while V7 continued to bring him back to his room. V7 said when they passed R1000's room, V7 heard R1000 yell to R1001 to be quiet and be respectful. V7 said R1001 responded to R1000 by telling R1000 to shut the f**k up and calling R1000 a fat*ss. On 6/11/25 at 1:57 PM, V8 said when she told V7 that R1001 could help, V8 meant that R1001 could use R1001's legs to help propel the wheelchair. V8 said she typically encourages residents to maintain their independence and get exercise by helping using their	S9999		

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S9999	Continued from page 3 legs to propel the wheelchair when able. On 6/11/25 at 9:25 AM, V2 said R1001 became so animated that his face turned a bright red and he was unable to be redirected. For the safety of the staff and residents, V2 called the police stating there was a large, irate gentleman that has been yelling and swearing. V2 said R1001 was finally became calm nearly 30 to 45 minutes after the police arrived and talked with him. R1000's medication administration record (MAR) for June shows R1000 received scheduled venlafaxine (anti-depressant/anti-anxiety medication) at 9:00 AM on 6/9/25. On 6/11/25 at 4:05 PM, V12 (Licensed Clinical Social Worker) said he meets with R1001 ideally once to twice a week. V12 said that R1001 has a tendency of skewing what people say to him and the intention of words said to him. R1001 can see or hear things in a certain manner and convinces himself of something that is not actually going on. V12 said sometimes R1001's thinking derails from reality. On 6/11/25 at 1:15 PM, V1 (Administrator) said he spoke with R1000 and R1000 described the incident with R1001 as being a form of verbal abuse. On 6/11/25 at 2:20 PM, V11 (Nurse Practitioner) said V2 notified her of the incident between R1000 and R1001. V11 said this is not the first time R1000 and R1001 have gotten into a similar altercation. Facility Abuse, Neglect, and Exploitation policy dated 11/2024 states, "It is the policy of the 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, and exploitation and misappropriation of resident property... "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... The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation	S9999		

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S9999	Continued from page 4 of resident property, and exploitation that achieves: ... D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect..." (B)	S9999		