STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	1111 West North 12th Street Shelbyville, IL 62565

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35046 Based on interview and record review the facility failed to ensure the right of being treated with respect and dignity for two (R1, R2) of four residents reviewed for abuse on the sample list of seven. Findings include: 1.) The facility's abuse investigation dated 8/9/24 at 3:00 PM documents, V4 (Certified Nurse's Assistant) allegedly said to R2 that no one likes R2, and no one wants to answer R2's call light. This investigation documents that abuse was unsubstantiated because R2 may have misunderstood V4 as R2 is hard of hearing. This investigation documents V4 will be educated regarding how to speak to R2. On 11/8/24 at 9:09 AM, R2 stated V4 worked with R2 for 5 or 6 weeks straight. R2 stated V4 acted like V4 didn't want to talk to anyone. R2 stated if R2 asked V4 to do something V4 would say stuff like, Don't start that. R2 stated R2 has to go to the bathroom a lot because R2 drinks a lot of water to prevent UTIs (urinary tract infections). R2 stated R2 would try to hold it so R2 wouldn't have to ask V4 for help. R2 stated V4 acted like V4 didn't want to be bothered. R2 stated V4 acted like V4 didn't want to put R2 to bed. R2 stated V4 was smart alecky and mad at the world. R2 stated V4 didn't want to work. R2 stated V4 wasn't mean and V4 did what R2 asked but wasn't happy. On 11/8/24 at 1:36 PM, V2 Director of Nursing stated it was reported that V4 allegedly told R2 that no one likes R2, and no one wants to answer R2's call light. V2 stated V2 talked to V4 about V4's tone. V2 stated when V2 interviewed R2 about V4; R2 stated R2 felt rushed when V4 provided R2's cares. V4's In-service education dated 8/14/24 documents V4 was educated to be concise when speaking so that there is no misunderstanding of intent, speak clearly and ask questions to ensure satisfaction of care, monitor speaking tone, make eye contact, respect the residents and go at their pace with their cares and do not rush. (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
	145441	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	1111 West North 12th Street Shelbyville, IL 62565

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) The facility's abuse investigation dated 10/23/24 documents on 10/23/24 at 3:40 PM, R1 reported to V3 Social Service Director that V4 Certified Nurse's Assistant was coming into R1's room opening and closing the door for no apparent reason and V4 is just always angry. This report documents V3 reported this to V2 Director of Nursing. The conclusion of this investigation documents abuse was not substantiated but documents V4 is inappropriate with her communications with the residents. This investigation documents staff believe V4 to be rude, gruff, abrupt, and hateful in V4's tone when speaking to residents. On 11/8/24 at 9:02 AM, R1 was lying in bed in R1's room. R1 stated V4 was mouthy. R1 stated when asking for help V4 would say loudly, What! R1 stated it was like I was on her time and V4 made R1 feel like V4 didn't want to take care of R1. R1 stated R1 would hear V4 say things like, Well what do they want? R1 stated if R1 didn't feel good V4 would say, You will be alright by noon. R1 stated R1 wants to be respected and V4 did not make R1 feel respected. On 11/8/24 at 9:39 AM, V3 Social Service Director stated R1 reported V4 was checking on R1 a lot and this made R1 nervous. V3 stated R1 stated V4 would open and close R1's door a lot and R1 wasn't sure why. V3 stated V3 told R1 that V3 would tell someone who would come down and talk to R1. V3 stated V3 went and got V2. On 11/8/24 at 1:40 PM, V2 stated on 10/23/24, V3 reported a concern to her regarding R1 and V4. V2 stated when talking to R1 she could tell R1 wanted to tell me something but wouldn't say too much. I went in and specifically asked her if she felt safe with V4. V2 stated R1 said V4 would come into R1's room frequently and then would leave and V4 would be in a bad mood and grumpy. V2 stated that this was the second time V2 received a complaint regarding V4 being verbally inappropriate. V2 stated V2 had educated V4 previously on how to speak and act towards residents so V2 decided it was best to cut their losses and let V4 go.