STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylorville Care Center	600 South Houston Taylorville, IL 62568

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to promote dignity and to treat residents in a respectful manner during care for 3 of 10 residents (R1, R2, and R4) reviewed for dignity in a sample of 10. Findings Include: R2's face sheet, print date of 4/30/25, documented R2 has diagnoses including flaccid hemiplegia affecting left dominant side and dysphasia following cerebral infarction, hypertension, hyperlipidemia, epilepsy, and arthritis. R2's MDS (Minimum Data Set), dated 3/22/25, documented R2 is cognitively intact, is dependent on a wheelchair and assistance for mobility, and is dependent on facility staff for hygiene needs including showers. R2's care plan, undated, documented category: psychosocial well-being, I am considered at risk for abuse/neglect per assessment with approaches including address all complaints/concerns promptly with grievance policy and procedure. Category ADLS (activities of daily living), resident needs limited to extensive assistance for activities of daily living related to CVA (cerebral vascular accident), flaccid on left side with approaches including transfer with assistance of 2 and a full body mechanical lift. R2's care plan also documented R2 is receiving restorative programs with goals to maintain present level of functioning. On 4/28/25 at 12:52 PM R2 stated he had an issue with a CNA (Certified Nurse Assistant) when she gave him a shower a few weeks ago. R2 stated the CNA used a hoist to transfer him onto the shower chair, the hoist hurt his private parts, she was rough, she acted like he had no rights, and she stated he does not have any rights. R2 stated his mom reported this to management but no one from management has talked to him about the incident. R2 then stated the CNA is (V11). On 4/28/25 at 1:15 PM V6 CNA stated she recently heard R2 say he doesn't like V11 to give him showers because she hurt him the last time, she gave him one. (continued on next page)

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

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 2:17 PM V1, Administrator, stated the facility does have a CNA named (V11). V1 then stated we did a write up on her about (R2) on C hall because his mom called and stated he had a bad experience with her during his shower. I didn't report it because there was no allegation of abuse when his mom called our Social Service Director. V1 stated V9, Social Service Director, spoke to R2's mom (V12) and V12 told her R2's privates were pinched from the sling. V1 then provided surveyor with a facility employee disciplinary form, dated 4/18/25, that documented employee (V11), summary of incident: resident states employee was being rough during shower. He states he asked several times for her to be easier with his genitals. Resident no longer wishes to have employee in his room or to provide care or to give shower. Employee educated on proper peri care/shower technique. This form documented signatures (all dated 4/18/25) by V1, V2 (former Director of Nursing), and V11. On 4/28/25 at 2:36 PM V9, Social Service Director, stated R2's mom (V12) called her and mentioned R2 was upset about the care he received during a shower, that the shower transfer sling had pinched his private area, and V12 requested that the CNA (V11) not shower R2 anymore. V9 said she did not document this in the facility grievance book, nor did she discuss this issue with R2 because she gave the information to the Administrator (V1). On 4/28/25 at 2:45 PM V1, Administrator, stated she did not interview R2 nor the other CNA working with V11. V1 then stated she did not investigate R2's allegation against V11. On 4/28/25 at 2:50 PM R2 stated the day V11 gave him a shower he informed V11 the transfer sling was hurting his privates, she did not reposition him or do anything to ease his discomfort, and that it felt like all his body weight was putting pressure on his testicles during the shower. R2 stated he was on the shower chair, it felt like the sling was not applied properly, he repeatedly told V11 that he was hurting, and V11 ignored his statements. R2 stated after the shower V11 did not dry him off and he was put to bed soaking wet. R2 stated no facility employees including management came and spoke to him about the incident, no nurses looked him over after the incident, so he told his mom (V12) and she called and reported it to someone at the facility. R2 stated he feels it was abuse and he will not allow V11 to care for him again. On 4/28/25 at 2:58 PM V10 CNA stated about 2 weeks ago R2 told him V11 had him sitting on his scrotum and she didn't reposition him when he told her it was hurting. On 4/28/25 at 3:37 PM V12, R2's mother, stated she called the facility's Social Service Director (V9) two weeks ago on 4/14/25 and informed her (V9) of her son's (R2) concerns with how he was treated by the CNA (V11) during his shower on 4/11/25. V12 stated R2 told her V11 was rough and rude, his private area was pinched, he was hurting during his shower, and the CNA (V11) would not reposition him. V12 stated R2 also told her V11 did not dry him off after his shower and she put him to bed soaking wet. V12 stated R2 informed her of the incident during her visit with him on 4/13/25. On 4/30/25 at 9:35 AM V9, Social Service Director, stated R2's mom, V12, did say V11 was rough with R2 during his shower. V9 stated she did not speak to R2 about his concerns because she took it to V1, Administrator, to follow up on. (continued on next page)

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 9:42 AM V11, CNA, stated the last time she gave R2 a shower was a couple of weeks ago on a Friday. V11 stated R2 normally speaks to her during care but he did not on this day, and she tried to speak with him throughout the shower, but he just cursed in response. V11 stated R2 never complained of pain during the shower. V11 stated she informed R2's nurse of his behavior during the shower. V11 stated she was never suspended pending an investigation of R2's allegation. On 4/30/25 at 11:15 AM V1, Administrator, stated she does not have any statements from R2, any other residents, nor staff other than the one on the write up that was given to V11. V1 then confirmed the facility did not complete an investigation of R2's allegations of V11 being rude and rough with him during a shower. 2. R1's, face sheet, print date of 4/30/25, documented R1 has diagnoses including congestive heart failure, atrial fibrillation, hypertension, atherosclerotic heart disease, and type 2 diabetes mellitus. R1's MDS, dated [DATE], documented R1 is moderately cognitively impaired although during interview with surveyor R1 was alert and oriented. This MDS also documented R1 requires partial to moderate assistance with showering indicating R1's helper/CNA does less than half the effort as R1 is able to complete most of his own shower. R1's care plan, undated, documented R1 is needs limited assistance for activities of daily living and is receiving restorative programs in order to maintain his present level of function. On 4/28/25 at 1:05 PM R1 stated he has had issues with the way (V11) CNA gives him showers. R1 stated we don't like the way she does things; she shows no respect to us, she has not abused me in anyway, she just doesn't show any respect. 3. On 4/28/25 at 1:08 PM R4 stated (V11) is not abusive, she just doesn't let us do as much as we can for ourselves when she showers us. She just does it. R4's MDS, dated [DATE], documented R4 is cognitively intact and independent with ADLS including showers. R4 ' s face sheet, print date of 4/30/25, documented R4 has diagnoses including congestive heart failure, depression, hypertension, and atherosclerotic heart disease. R4 ' s care plan, undated, documented R4 requires supervision for activities of daily living prn (as needed) and is independent with transfers,

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49494 Based on interview and record review the facility failed to report an allegation of verbal and physical abuse to the State Agency for 1 (R2) of 3 residents reviewed for abuse in the sample of 10. Findings Include: R2's face sheet, print date of 4/30/25, documented R2 has diagnoses including flaccid hemiplegia affecting left dominant side and dysphasia following cerebral infarction, hypertension, hyperlipidemia, epilepsy, and arthritis. R2's MDS (Minimum Data Set), dated 3/22/25, documented R2 is cognitively intact, is dependent on a wheelchair and assistance for mobility, and is dependent on facility staff for hygiene needs including showers. R2's care plan, undated, documented category: psychosocial well-being, I am considered at risk for abuse/neglect per assessment with approaches including address all complaints/concerns promptly with grievance policy and procedure. Category ADLS (activities of daily living), resident needs limited to extensive assistance for activities of daily living related to CVA (cerebral vascular accident), flaccid on left side with approaches including transfer with assistance of 2 and a full body mechanical lift. On 4/28/25 at 12:52 PM R2 stated he had an issue with a CNA (Certified Nurse Assistant) when she gave him a shower a few weeks ago. R2 stated the CNA used a hoist to transfer him onto the shower chair, the hoist hurt his private parts, she was rough, she acted like he had no rights, and she said stated he does not have any rights. R2 stated his mom reported this to management but no one from management has talked to him about the incident. R2 then stated the CNA is (V11). On 4/28/25 at 2:17 PM V1, Administrator, stated the facility does have a CNA named (V11). V1 then stated we did a write up on her about (R2) on C hall because his mom called and stated he had a bad experience with her during his shower. I didn't report it because there was no allegation of abuse when his mom called our Social Service Director. V1 stated V9, Social Service Director, spoke to R2's mom (V12) and V12 told her R2's privates were pinched from the sling. V1 then provided surveyor with a facility employee disciplinary form, dated 4/18/25, that documented employee (V11), summary of incident: resident states employee was being rough during shower. He states he asked several times for her to be easier with his genitals. Resident no longer wishes to have employee in his room or to provide care or to give shower. Employee educated on proper peri care/shower technique. This form documented signatures (all dated 4/18/25) by V1, V2 (former Director of Nursing), and V11. On 4/28/25 at 2:36 PM V9, Social Service Director, stated R2's mom (V12) called her and mentioned R2 was upset about the care he received during a shower, that the shower transfer sling had pinched his private area, and V12 requested that the CNA (V11) not shower R2 anymore. V9 said she did not document this in the facility grievance book, nor did she discuss this issue with R2 because she gave the information to the Administrator (V1). (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 2:45 PM V1, Administrator, stated she did not interview R2 nor the other CNA working with V11. V1 then stated she did not investigate R2's allegation against V11. On 4/28/25 at 2:50 PM R2 stated the day V11 gave him a shower he informed V11 the transfer sling was hurting his privates, she did not reposition him or do anything to ease his discomfort, and that it felt like all his body weight was putting pressure on his testicles during the shower. R2 stated he was on the shower chair, it felt like the sling was not applied properly, he repeatedly told V11 that he was hurting, and V11 ignored his statements. R2 stated after the shower V11 did not dry him off and he was put to bed soaking wet. R2 stated no facility employees including management came and spoke to him about the incident, no nurses looked him over after the incident, so he told his mom (V12) and she called and reported it to someone at the facility. R2 stated he feels it was abuse and he will not allow V11 to care for him again. On 4/28/25 at 3:37 PM V12, R2's mother, stated she called the facility's Social Service Director (V9) two weeks ago on 4/14/25 and informed her (V9) of her son's (R2) concerns with how he was treated by the CNA (V11) during his shower on 4/11/25. V12 stated R2 told her V11 was rough and rude, his private area was pinched, he was hurting during his shower, and the CNA (V11) would not reposition him. V12 stated R2 also told her V11 did not dry him off after his shower and she put him to bed soaking wet. V12 stated R2 informed her of the incident during her visit with him on 4/13/25. On 4/30/25 at 9:35 AM V9, Social Service Director, stated R2's mom, V12, did say V11 was rough with R2 during his shower. V9 stated she did not speak to R2 about his concerns because she took it to V1, Administrator, to follow up on. On 4/30/25 at 9:42 AM V11, CNA, stated the last time she gave R2 a shower was a couple of weeks ago on a Friday. V11 stated R2 normally speaks to her during care but he did not on this day, and she tried to speak with him throughout the shower, but he just cursed in response. V11 stated R2 never complained of pain during the shower. V11 stated she informed R2's nurse of his behavior during the shower. V11 stated she was never suspended pending an investigation of R2's allegation. On 4/30/25 at 11:15 AM V1, Administrator, stated she does not have any statements from R2, any other residents, nor staff other than the one on the write up that was given to V11. V1 then confirmed the facility did not complete an investigation of R2's allegations of V11 being rude and rough with him during a shower. On 4/30/25 at 12:53 PM V1, Administrator, stated she did not report R2's allegation about V11 being rough with him during a shower. On 4/30/25 at 12:56 PM V15, Director of Operations, stated R2's allegations against the CNA (V11) should have been reported and investigated. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Prevention Program policy, dated 9/29/22, documented abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. It continues, 8. External Reporting of Potential Abuse: Initial reporting of allegations. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: a. Must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the event that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. It continues, d. Five-day final abuse investigation report. Within 5 working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to operationalize their policy to conduct an investigation of allegations of physical and verbal abuse for 1 (R2) of 3 residents reviewed for abuse in the sample of 10. Findings Include: R2's face sheet, print date of 4/30/25, documented R2 has diagnoses including flaccid hemiplegia affecting left dominant side and dysphasia following cerebral infarction, hypertension, hyperlipidemia, epilepsy, and arthritis. R2's MDS (Minimum Data Set), dated 3/22/25, documented R2 is cognitively intact, is dependent on a wheelchair and assistance for mobility, and is dependent on facility staff for hygiene needs including showers. R2's care plan, undated, documented category: psychosocial well-being, I am considered at risk for abuse/neglect per assessment with approaches including address all complaints/concerns promptly with grievance policy and procedure. Category ADLS (activities of daily living), resident needs limited to extensive assistance for activities of daily living related to CVA (cerebral vascular accident), flaccid on left side with approaches including transfer with assistance of 2 and a full body mechanical lift. On 4/28/25 at 12:52 PM R2 stated he had an issue with a CNA (Certified Nurse Assistant) when she gave him a shower a few weeks ago. R2 stated the CNA used a hoist to transfer him onto the shower chair, the hoist hurt his private parts, she was rough, she acted like he had no rights, and she said stated he does not have any rights. R2 stated his mom reported this to management but no one from management has talked to him about the incident. R2 then stated the CNA is (V11). On 4/28/25 at 1:05 PM R1 stated he has had issues with the way (V11) CNA gives him showers. R1 stated we don't like the way she does things; she shows no respect to us, she has not abused me in anyway, she just doesn't show any respect. R1's MDS, dated [DATE], documented R1 is moderately cognitively impaired although during interview with surveyor R1 was alert and oriented. On 4/28/25 at 1:08 PM R4 (R1's roommate) stated (V11) is not abusive, she just doesn't let us do as much as we can for ourselves when she showers us. She just does it. R4's MDS, dated [DATE], documented R4 is cognitively intact. On 4/28/25 at 1:15 PM V6 CNA stated she recently heard R2 say he doesn't like V11 to give him showers because she hurt him the last time, she gave him one. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 2:17 PM V1, Administrator, stated the facility does have a CNA named (V11). V1 then stated we did a write up on her about (R2) on C hall because his mom called and stated he had a bad experience with her during his shower. I didn't report it because there was no allegation of abuse when his mom called our Social Service Director. V1 stated V9, Social Service Director, spoke to R2's mom (V12) and V12 told her R2's privates were pinched from the sling. V1 then provided surveyor with a facility employee disciplinary form, dated 4/18/25, that documented employee (V11), summary of incident: resident states employee was being rough during shower. He states he asked several times for her to be easier with his genitals. Resident no longer wishes to have employee in his room or to provide care or to give shower. Employee educated on proper peri care/shower technique. This form documented signatures (all dated 4/18/25) by V1, V2 (former Director of Nursing), and V11. On 4/28/25 at 2:36 PM V9, Social Service Director, stated R2's mom (V12) called her and mentioned R2 was upset about the care he received during a shower, that the shower transfer sling had pinched his private area, and V12 requested that the CNA (V11) not shower R2 anymore. V9 said she did not document this in the facility grievance book, nor did she discuss this issue with R2 because she gave the information to the Administrator (V1). On 4/28/25 at 2:45 PM V1, Administrator, stated she did not interview R2 nor the other CNA working with V11. V1 then stated she did not investigate R2's allegation against V11. On 4/28/25 at 2:50 PM R2 stated the day V11 gave him a shower he informed V11 the transfer sling was hurting his privates, she did not reposition him or do anything to ease his discomfort, and that it felt like all his body weight was putting pressure on his testicles during the shower. R2 stated he was on the shower chair, it felt like the sling was not applied properly, he repeatedly told V11 that he was hurting, and V11 ignored his statements. R2 stated after the shower V11 did not dry him off and he was put to bed soaking wet. R2 stated no facility employees including management came and spoke to him about the incident, no nurses looked him over after the incident, so he told his mom (V12) and she called and reported it to someone at the facility. R2 stated he feels it was abuse and he will not allow V11 to care for him again. On 4/28/25 at 2:58 PM V10 CNA stated about 2 weeks ago R2 told him V11 had him sitting on his scrotum and she didn't reposition him when he told her it was hurting. On 4/28/25 at 3:37 PM V12, R2's mother, stated she called the facility's Social Service Director (V9) two weeks ago on 4/14/25 and informed her (V9) of her son's (R2) concerns with how he was treated by the CNA (V11) during his shower on 4/11/25. V12 stated R2 told her V11 was rough and rude, his private area was pinched, he was hurting during his shower, and the CNA (V11) would not reposition him. V12 stated R2 also told her V11 did not dry him off after his shower and she put him to bed soaking wet. V12 stated R2 informed her of the incident during her visit with him on 4/13/25. R2's shower sheet, dated 4/11/25, documented V11 CNA did give R2 a shower on 4/11/25. On 4/30/25 at 9:35 AM V9, Social Service Director, stated R2's mom, V12, did say V11 was rough with R2 during his shower. V9 stated she did not speak to R2 about his concerns because she took it to V1, Administrator, to follow up on. (continued on next page)

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