

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145836	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/18/2025
NAME OF PROVIDER OR SUPPLIER  Shelbyville Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  2116 South 3rd Dacey Drive 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</b></p> <p>Based on interview and record review the facility failed to ensure residents were treated with dignity for two (R2, R3) residents out of three residents reviewed for abuse in a sample list of six residents.</p> <p>Findings include:</p> <p>The Illinois Long Term Care Ombudsman Program pamphlet titled Resident Rights for People in Long Term Care Facilities revised November 2018 documents the facility must treat the resident with dignity and respect and must care for the resident in a manner that promotes the residents' quality of life.</p> <p>R2 and R3's shared Final Report to the State Agency dated 2/18/25 documents R2 and R3 reported that at times V13 (Licensed Practical Nurse/LPN) could be short with her responses but denied that she was mentally or verbally abusive to (R2, R3).</p> <p>R2 and R3's shared abuse investigation documents V13 (LPN) was in-serviced on 2/17/25 on Tone of voice when responding to residents' customer service, communication, and interacting with residents during medication pass.</p> <p>1. R2's Minimum Data Set (MDS) date 1/4/2025 documents R2 as cognitively intact.</p> <p>On 2/14/25 at 2:10 PM R2 stated V13 (LPN) is a night nurse at the facility. R2 stated V13 is rude and pushy. R2 stated I get up in the night to use the bathroom and most times I can do things on my own. Some nights I need a little help. When V13 comes in my room, the whole atmosphere changes. V13 tells me to hurry up and quit wasting her time. R2 stated V13 has a very bad attitude and does not want to take care of residents. R2 stated he feels safe living at facility. R2 stated V13 never physically abused me or anything like that. But V13 treats me like a dog, and I don't like it.</p> <p>2. R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact.</p> <p>(continued on next page)</p>

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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/14/25 at 2:25 PM R3 stated V13 is rude, hateful and mean to R3. R3 stated I am a smoker. I know the smoking times. The last time to smoke in the evening is 7:00 PM. When I ask V13 to go out to smoke, V13 tells me to 'go sit down' or 'go away' or 'I don't have time for you. Leave me alone.' V13 hasn't called me any names but she is just so hateful. R3 stated V13's bad attitude and rudeness to the residents was discussed in the last Resident Council Meeting (1/22/25). R3 stated no one has talked to her about her concerns with V13 LPN's rude statements towards R3. R3 stated I don't feel like I was abused. I feel safe here. But I also don't deserve to be talked to like that especially by someone in authority like a nurse.</p> <p>On 2/18/25 at 11:30 AM V1 (Administrator in Training/AIT) stated R2 and R3 both reported that V13 (LPN) can be 'short' and 'rude' when having interactions with R2 and R3. V1 stated when V1 spoke with V13, V13 stated sometimes she does get tired and that could be taken as rude and/or pushy. V1 stated V1 in-serviced V13 on appropriate behavior and tone of voice when interacting with residents. V1 stated the conclusion of her investigation was that R2 and R3 were not mentally and/or verbally abused but also do deserve better from the staff. V1 stated V13 LPN's behavior was not appropriate and she has now been in-serviced and expected to do better.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41970</p> <p>Based on interview and record review the facility failed to ensure the safety of one (R1) resident from physical abuse by a staff member out of three residents reviewed for abuse in a sample list of six residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents medical diagnoses as Dementia, Psychotic Disorder with Hallucinations, Muscle Weakness, Unsteady on Feet, Reduced Mobility, Restless and Agitation and Violent Behavior.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 as severely cognitively impaired. This same MDS documents R1 as independent in toileting, dressing, personal hygiene, bed mobility, moving from a sitting to standing position and able to self-propel her wheelchair 150 feet.</p> <p>R1's AIM for Wellness dated 1/29/25 documents R1 had an alleged unintentional change in plane and an altercation with a staff member (V3) Certified Nursing Assistant/CNA. This same report documents (R1) was arguing with (R5) and (V3) CNA. (R1) was also upset with (V3) CNA when V3 CNA tried to redirect and take (R1) back to her room. Possible precursors to event: (R1) agitated with (R5) and agitated with (V3) CNA.</p> <p>R1's Final Report to the State Agency dated 2/6/25 documents While (R1) was being taken to her room, she attempted to stand up so (V3) Certified Nurse Aide (CNA) placed her hand around (R1's) tricep in an attempt to prevent the fall, but (R1) landed on her bottom. (R1) stated that her arm hurt because (V3) grabbed her arm and pushed her down. Upon assessment a red handprint was found on (R1's) Right Arm.</p> <p>V3 (CNA) Employee file documents V3 CNA was Terminated due to attitude while being in the probationary period.</p> <p>On 2/14/25 at 10:20 AM R1 was sitting in her wheelchair in her room. R1 stated a girl (V3) (CNA) pushed her down. R1 used her Left Hand to rub the inside of her Right Upper arm while stating she bruised me hard.</p> <p>On 2/14/25 at 10:35 AM V4 (Licensed Practical Nurse/LPN) assessed R1's Right Upper Arm. V4 stated R1 did have several bruises in the same area. V4 stated R1 does have Dementia but is able to remember certain events. V4 stated R1 has mentioned her bruised arm several times since the event on 1/29/25. R1's Right Upper Inner Arm showed a quarter sized slightly yellow area. R1 stated during assessment That is the place. That is where she (V3) Certified Nurse Aide (CNA) hurt me.</p> <p>On 2/14/25 at 10:40 AM V5 (CNA) stated she was working the same night V3 (CNA) and R1 had some type of altercation. V5 stated she heard R1 hollering so she went to investigate and saw R1 laying on the floor with V3 standing next to R1. V5 stated R1 appeared to be very upset. V5 stated V3 was just saying I need to be sent home and Tell the nurse to send me home.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/14/25 at 11:40 AM V8 (LPN) stated V8 was the nurse for R1 on 1/29/25. V8 stated she was passing medications around 7:00 PM- 8:00 PM at the end of the 400 hall which conjoins with the end of the 100 hall. V8 stated she was in the corner where the 400 and 100 halls meet with her back to the 100 hall. V8 stated she heard R1 yelling out loudly. V8 stated she was never approached by any staff and did not hear any staff yelling out. V8 stated she only heard R1's voice and she sounded scared. V8 stated when she turned around to investigate why R1 was yelling, V8 saw R1 laying on the floor with V3 (CNA) standing over R1. V8 stated V3 CNA was visibly frustrated and mad looking and stating You need to send me home. Send me home right now! After I had made sure (R1) was stable, I went to get a statement from (V3) CNA because she had just walked away. V8 stated V3 was assisting another resident (R4). V8 stated V3 reported to V8 that R1 was upset due to an altercation with two other residents (R5, R6) at the dining room table. V8 stated (V3) CNA told me that (V3) had told (R1) to calm down or (R1) would have to go to her room. (R1) became more agitated so (V3) was trying to take (R1) to her room. (R1) stood up out of her wheelchair, became unsteady on her feet so (V3) tried to grab (R1) by the arm to prevent her from falling. (V3) said (R1) sat herself on the floor on her bottom. (R1) wasn't sitting on her bottom when I first saw her. (R1) was laying on her Left side. V8 stated V2 (Director of Nurses/DON) came to the facility that night to assess R1.</p> <p>On 2/14/25 at 12:20 PM V2 (DON) stated V8 (LPN) called V2 the evening of 1/29/25 to report a fall/incident between V3 (CNA) and R1. V2 (DON) stated she went to the facility and saw R1's arm to have two finger shaped contact/dyscoloration marks on R1's Right Upper Inner Arm. V2 stated the marks were consistent with V3 CNA's story, so she was not thinking that R1 had been subjected to abuse. V2 stated R1 reported to her the morning of 1/30/25 that She (V3) was a strong woman and (V3) pushed me down to the ground while pointing to her Right Arm. V2 DON stated, At that point, I called (V3) CNA and suspended her pending an investigation. V2 DON stated V3 had called V2 before V2 could arrive at the facility and stated I need to go home. I am so overwhelmed. V2 stated V3 had already left by the time V2 arrived at the facility. V2 stated V8 (LPN) reported that R1 had been upset with other residents (R5, R6) at her dining room table when V3 (CNA) attempted to deescalate the situation. V2 stated it was reported that V3 told R1 to stop her behaviors or V3 would take R1 to her room and when R1 was still agitated, V3 attempted to push R1 in her wheelchair to R1's room. V2 (DON) stated she was told R1 tried to stand up, was unsteady, V3 CNA grabbed R1's arm to try to keep her from falling and R1 put herself on the floor.</p> <p>On 2/14/25 at 12:30 PM V2 (DON) stated V3 (CNA) should have removed the other residents from R1's table to help deescalate a behavioral situation with R1. V2 stated V3 should have called on other staff when R1 was becoming more and more agitated. V2 stated Telling (R1) to go to her room because she is not behaving the way (V3) wanted her to is never appropriate. V2 stated V3 was suspended and subsequently terminated due to her poor attitude.</p> <p>On 2/14/25 at 12:50 PM V1 (Administrator in Training/AIT) stated V9 (Regional Director of Operations) spoke with V3 (CNA) on 1/30/25 when both V1 and V9 were informed of an incident between R1 and V3. V1 stated R1 was mad due to R5 was touching other residents' belongings at the dining room table where R1 was also sitting. V1 stated it was reported to V1 that R1 stood up and V3 grabbed R1's arm to keep her from falling but R1 fell on her bottom. V1 stated R1 told her on the morning of 1/30/25 that V3 was 'pushy'. V1 stated V3 was called and notified that she was suspended. V1 stated V3 was terminated due to poor performance, and she was still in her probationary period. V1 stated the facility is unable to provide any documentation of V3 having any Abuse or Dementia training from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/14/25 at 3:00 PM V3 (CNA) stated on the evening of 1/29/25 after supper, R1 was sitting at a dining room table with R5 and R6. V3 stated R5 was 'messaging' with items on the table and R6's walker. V3 stated R1 was agitated about R5 messing with R6's belongings and started yelling at R5 to stop touching everything. V3 stated to R1 Stop yelling and calm down or I will put you in your room. V3 stated R1's behavior became worse after that, so V3 tried to push R1 in her wheelchair to R1's room. V3 stated We (R1, V3) didn't get very far in her wheelchair. (R1) was pushing against it trying not to go to her room. Then (R1) stood up out of the wheelchair and walked two to three steps. (R1) grabbed ahold of the water cart to gain leverage to get away from me. (R1) wouldn't let go of the water cart. I had to really grab her hard to make her let go of the water cart. I kept saying 'Calm down or you are going to your room!'. I walked around the front of the wheelchair. I grabbed (R1's) Right arm when she was facing me. I was right in front of (R1) and used my Right Hand to grab her Right Arm. That is when (R1) swung around and fell , landing on her Left side. I was trying to put (R1) back in her wheelchair to take her to her room. V3 stated R5 and R6 sat at the dining room table and witnessed the entire situation. V3 stated she has not had any Dementia or Abuse training with this facility. V3 stated V3 should have removed R5 and R6 to try to deescalate R1. V3 stated I was overwhelmed and frustrated that evening. I should have just gotten someone else to help so (R1) would never have fallen or gotten hurt. I hate that (R1) was bruised by me. I feel bad about that. I look back and see how many things I should have done differently. I should have just backed away from the whole situation because I was just as frustrated as (R1) and that is when things like that happen.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41970</p> <p>Based on interview and record review the facility failed to report a concern voiced in Resident Council Meeting of a staff members poor demeanor towards two (R2, R3) residents out of three residents reviewed for abuse in a sample list of six residents.</p> <p>Findings include:</p> <p>The facility policy titled Abuse Prevention Program revised May 2021 documents Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriate of resident property they observe, hear about, or suspect to a supervisor and the Administrator. Upon learning of the report, the Administrator or designee shall initiate an investigation.</p> <p>The facility Resident Council Minutes dated 1/22/25 document resident concerns of night nurse (V13) Licensed Practical Nurse (LPN) demeanor towards residents. These same minutes document V12 (Previous Activity Director) as the staff liaison for this resident council meeting.</p> <p>On 2/14/25 at 2:10 PM R2 stated V13's 'poor demeanor' was discussed in January's Resident Council meeting. R2 stated someone usually will come talk to him about concerns brought up during the meetings but this time no one ever asked him anything. R2 stated V12 (Previous Activity Director) was present and taking minutes for the January meeting.</p> <p>On 2/14/25 at 2:25 PM R3 stated V13's bad attitude and rudeness to the residents was discussed in the last Resident Council Meeting (1/22/25). R3 stated no one has talked to her about her concerns with V13 LPN's rude statements towards R3.</p> <p>On 2/14/25 at 2:40 PM V1 (Administrator in Training/AIT) stated she was not aware of the concerns documented on the January 2025 Resident Council Meeting. V1 stated V12 would conduct the meetings and then report any concerns to V1. V1 stated after reading the January Resident Council Minutes that there was a concern about V13's LPN behavior V12 should have reported to V1 immediately due to this as an allegation of mental/verbal abuse so that V1 could initiate an investigation.</p>		