STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. Building B. Wing	06/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Healthcare & Senior Living	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse by another resident. This failure affects four of four residents (R1, R2, R3, R4) reviewed for abuse in a sample list of four residents. Findings include: 1. The facility policy titled Abuse Prevention Program with revision date of 11/2016 documents the facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. The same policy documents residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately be evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility. R2's undated Face Sheet documents medical diagnoses of Cerebral Infarction, unspecified and Unspecified Dementia, Moderate with Agitation. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 requires a wheelchair for mobility. R1's undated Face Sheet documents medical diagnoses of Parkinsonism, unspecified, Major Depression Disorder and Anxiety Disorder. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired. This same MDS documents R1 requires a wheelchair for mobility. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated 4/28/25 and revised on 5/5/25 documents Behavior: R1 is/has the potential to be physically and verbally aggressive toward staff and residents related to Dementia and poor impulse control. Interventions on R1's care plan include If agitation continues take resident to a calm, quiet area and turn TV on, date initiated 4/28/25 and When R1 becomes agitated Intervene before agitation escalates; guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. On 5/14/25 at 8:10 AM R1's Progress notes documented by V2 (Previous Director of Nurses/DON), state R1 had an aggressive event this morning and R1 was taken to the dining room for breakfast to try to let R1 calm down. R2 was wheeling herself to the kitchen serving window and was headed towards R1's table, which caused R1 to become upset and more agitated and when R2 was close enough to the table R1 reached out and grabbed R2's hand and slammed R2's hand down onto the table. On 6/22/25 at 1:05 PM V6 (Certified Nurse Assistant/CNA) stated in interview I was sitting at the table feeding another resident when (R1) was placed at the table. (R2) was wheeling herself to the kitchen serving window to get a drink and (R1) became very agitated when he saw her move toward the table, when (R2) was close enough (R1) grabbed her hand and slammed it down on the table. I immediately got up and asked very calmly for (R1) to please let (R2's) hand go and (R1) did. I ask (R2) if she was hurt and (R2) stated no and went up to the serving window to get a drink. V6 stated she reported the incident to the charge nurse. On 6/22/25 at 1:45 PM V4 (Social Service Designee) stated I am usually the one who takes (R1) to another place in the building for (R1) to calm down. When I heard they took (R1) to the dining room I did not understand why because we are to take (R1) to a calm area, not a noisy one like the dining room. On 6/22/25 at 2:15 PM V1 (Administrator) stated (R1) had a medication change that week and I believe it made (R1) more agitated than usual. (R1) was transferred to the ED (Emergency Department) for evaluation of medication but the ED sent (R1) right back and gave (R1) a shot of Haldol (antipsychotic) for his aggression. 2. The Facility Incident Report dated 5/28/25 describes a resident-to-resident incident taking place on 5/21/25 at 7:30 PM. The Incident Report documents R4 was walking toward R3's table and R3 struck R4 on the hand because R4 was walking toward the table. R3's MDS (Minimum Data Set) dated 6/5/25 documents R3 is cognitively impaired and can walk with assistance. R3's Care Plan dated 5/22/25 documents the following diagnoses for R3: Psychotic Disturbance with Mood Disturbance, Unspecified Dementia Moderate with Behavioral Disturbance and Psychotic Disorder with Hallucinations. R3's Care Plan addresses R3's issues with others approaching her area around the table R3 sits at. The Care Plan documents interventions to implement when R3 becomes aggressive with residents or staff. R4's MDS dated [DATE] documents R4 as being cognitively impaired and walks about the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Care Plan revision date of 5/28/25 documents the following diagnoses for R4: Unspecified Dementia, Unspecified Severity without Behavioral Disturbances, Psychotic Disturbance, Mood Disturbances and Anxiety. The Care Plan addresses R4 as having wandering behaviors and directs staff to keep R4 busy so R4 will not wander about the facility into other resident's rooms. On 6/22/25 at 1:00PM V1 (Administrator) stated they are contacting R3's family to have a meeting about R3's aggressive behavior toward residents and staff. V1 stated the new intervention is to have a staff member available whenever R3 goes to the dining room.