STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146017	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Illini Heritage Rehab & Hc	1315 Curt Drive, Suite B Champaign, IL 61821

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** 32172 Based on interview and record review the facility failed to protect the resident's right to be free from verbal and mental abuse by a staff member. This failure affected one of four residents (R1) reviewed for abuse in the sample of four. Findings Include: The facility's Abuse Prevention Program dated 11/28/16 documents the facility affirms the right of it's residents to be free from abuse or mistreatment. The facility is committed to protecting the residents from abuse. Abuse includes the willful intimidation resulting in mental anguish which can include verbal or mental abuse. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Mental abuse includes humiliation. The Abuse Investigation Report dated 5/22/24 documents V3 Certified Nurses Assistant (CNA) was verbally inappropriate towards R1. V3 made R1 feel embarrassed by the way V3 spoke to her and by V3's behavior in the dining room. The facility found that V3 engaged in inappropriate and unprofessional behavior directed towards R1. V3 was terminated after the conclusion of the investigation. R1's Physician Order Sheet dated May 2024 documents R1 is diagnosed with Congestive Heart Failure, Depression, Bipolar Disorder, Post Traumatic Stress Disorder and Neuropathy. R1's Cognitive assessment dated [DATE] documents R1 is cognitively intact. (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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 3:40 PM, R1 stated she was waiting behind another resident to get a drink after lunch- at around 1:30 PM. When she got up to the kitchen window V10 Cook was on break and V3 CNA was in the kitchen. R1 asked V3 to get her some hot chocolate. V3 CNA began to raise her voice and tell R1 that it wasn't her job. R1 told V3 that V10 Cook was on break so that's why R1 was asking V3. V3 then went on and on about how the staff deserve breaks too and asked R1 if she thinks staff deserve breaks. R1 replied- of course staff deserve breaks but V10 Cook takes one every thirty minutes. V3 CNA was upset and yelling and cursing about how she was tired of this sh*t and staff deserve breaks and complaining that she had to get R1's hot chocolate. V3 finally got the hot chocolate and set it on the counter in front of R1 and walked away. R1 stated she was so embarrassed and felt humiliated that V3 had spoken to her so harshly and with such a loud tone. V3 made a huge scene and made R1 feel like she was a burden. R1 stated she has never been made to feel that way before and she has never been talked to that way before. R1 stated it was like her needs meant nothing and V3 did not want to help R1. R1 stated V3 CNA made her feel horrible and very upset. R1 stated she did not deserve to be treated that way and she did not deserve to be made to feel like she was a burden. R1 confirmed she feels she was mentally and verbally abused by V3 CNA. R1 reported the incident to V4 Assistant Director of Nurses as soon as she saw her and then went down to her room. R1 stated as she was in the hallway getting out of her electric wheelchair, V3 CNA walked by and snapped at R1 and said, Thanks a lot (R1), now you got me in trouble. R1 stated V3 said it very meanly and seemed angry. R1 stated she was so upset and she went into her room and cried. The Notice of Termination dated 5/27/24 documents V3 CNA was terminated for inappropriate verbal behavior regarding a resident resulting in investigation. Termination occurred after conclusion of investigation. On 5/31/24 at 11:45 AM, V1 Administrator confirmed per resident interview the incident did occur and V3 was terminated after the conclusion of the investigation in part for inappropriate verbal behavior.