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	07/29/2024

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. 42702 Based on interview and record review the facility failed to protect two (R1 and R2) of three residents from verbal and mental abuse from a total sample of three residents reviewed for abuse. Findings include: The facility provided Abuse Prevention Program Policy dated 11/28/2016 documents that the facility affirms the right of its' residents to be free from abuse or mistreatment including protecting residents from verbal abuse from staff. Verbal abuse is identified in the policy as 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. Examples of verbal abuse include but are not limited to threats of harm, or saying things to frighten a resident. Mental abuse includes threats of punishment or deprivation. On 7/29/24 at 9:00AM, R1 was sitting at the table in the dining room. R1 did not respond to verbal communication. R1's 7/14/23 cognitive assessment documents R1 as severely cognitively impaired. R2's 6/13/24 cognitive assessment documents R2 as cognitively intact. On 7/25/24 at 1:30PM, V1 Administrator said that R1 has a lot of behaviors in the dining room, rolling up to the counter and getting into things. On 7/25/24 at 2:00PM, V5 Certified Nursing Assistant (CNA) said that she witnessed the incident between R1 and V4 [NAME] on July 13, 2024. V5 CNA said that the dietary department was short on the night in question. When I came into the dining room, (V4 Cook) was yelling at (R1) and at me saying that if you don't do something with him, I'm leaving. V4 [NAME] then told R1 that he wasn't going to feed anyone if he didn't go back and sit at his table and that (R1) was definitely eating last. I then saw (R1) reach for something on the counter and V4 [NAME] raised his hand to hit R1. I quickly moved R1 away so that there could be no contact. It was shocking to me and he made R1 wait until last to eat. (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	On 7/25/24 at 2:30PM, R2 said that she remembered seeing V4 [NAME] yell at R1 a few weeks ago and that it was very upsetting. R2 said that she told V3 Resident Care Coordinator about it that night. R2 said that V4 was yelling at R1 for messing things up on the counter before supper and that she saw V4 [NAME] raise his hand to hit R1, but V5 Certified Nursing Assistant (CNA) moved R1 before V4 could hit him. On 7/25/24 at 1:30PM, V1 Administrator said that on 7/13/24 he was made aware of an incident where V4 [NAME] told R1 that he was going to stop serving dinner if he didn't quit trying to get into things and that R1 would be served last. I terminated V4 [NAME] for his behavior toward a resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42702 Based on interview and record review the facility failed to implement its abuse policy by failing to immediately report suspected abuse to the abuse coordinator and failing to ensure that the alleged abuser was immediately removed from the facility for two (R1 and R2) of three residents reviewed for abuse from a total sample list of three. Findings include: The facility Abuse Prevention Program Policy dated 11/28/16 documents that employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatement, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents. The facility initial reportable documents that an altercation between R1 and V4 [NAME] occurred on 7/13/24 at the evening meal. The facility provided investigation documents that the incident between R1 and V4 [NAME] occurred on 7/13/24 at approximately 4:45PM. The facility provided schedule documents that V5 Certified Nursing Assistant was on duty at the time of the incident between R1 and V4 Cook. On 7/25/24 at 2:00PM, V5 Certified Nursing Assistant (CNA) said that she witnessed the incident between R1 and V4 [NAME] on July 13, 2024. V5 CNA said that the dietary department was short on the night in question. When I came into the dining room, (V4 Cook) was yelling at (R1) and at me saying that if you don't do something with him, I'm leaving. V4 [NAME] then told R1 that he wasn't going to feed anyone if he didn't go back and sit at his table and that (R1) was definitely eating last. I then saw (R1) reach for something on the counter and V4 [NAME] raised his hand to hit R1. I quickly moved R1 away so that there could be no contact. It was shocking to me. On 7/25/24 at 2:15PM, V3 Resident Care Coordinator (RCC) said that she entered the facility on July 13, 2024 at approximately 5:30PM and that after awhile R2 told her that V4 [NAME] had been mean to R1 and had threatened him with hitting and said that he wasn't going to feed us if (R1) didn't stop. On 7/24/24 at 2:03PM, V5 CNA said that when V3 Resident Care Coordinator came in that evening at approximately 6:15PM, R2 told V3 RCC what had happened between R1 and V4 Cook. V3 RCC then asked (V5 CNA) if it was true. I told her what I saw between R1 and V4 [NAME] and she told me that we had to report it to V1 Administrator and V2 DON immediately. At this point, V4 [NAME] had already gone home. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 V2 Director of Nursing (DON) said that V3 RCC texted both V2 DON and V1 Administrator at 6:25PM on July 13, 2024 to report the incident. On 7/25/24 at 1:30PM, V1 Administrator said that he was contacted the evening of the occurrence and came into the facility immediately. V4 [NAME] had already left the facility when I got there, but I don't know why he started dinner so early or why he left early. V4 Cook's time card documents an out scan on 7/13/24 at 5:31PM.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to employ a clinically qualified Director of Food and Nutrition. This failure has the potential to affect all 49 residents residing in the facility. Findings include: The facility assessment dated [DATE] documents that a dietician or other clinically qualified nutrition professional will serve as the director of food and nutrition services. The facility provided dietary schedule documents no dietary manager until July 25, 2024 and no certified dietary manager on staff during the month of July 2024. On 7/25/24 at 1:45PM, V1 Administrator said that he had been cooking for the last 12-14 days due to lack of staff, including a dietary manager. V1 Administrator then said that he hired V8 dietary manager who started orientation on 7/25/24. On 7/29/24 at 11:25PM, V1 Administrator said that the only documented training that V8 Dietary Manager has provided is a food handler's certificate and that he could not provide documentation that V8 was a certified dietary manager or had other credentials to support her knowledge of the role.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to employ sufficient staffing with the appropriate competencies to provide food service. This failure has the potential to affect all 49 residents who reside in the facility. Findings include: The facility food service staffing and scheduling policy dated 12/2006 documents that it is the policy (facility name)Health Care that sufficient, competent support personnel are employed to carry out the functions of the department. The facility assessment dated [DATE] documents that the dietary department needs include 8 hours of a director of food and nutrition services and 12 hours of food and nutrition services staff per day. On 7/25/24 at 1:45PM, V1 Administrator said that he had been cooking for the last 12-14 days due to lack of staff, including a dietary manager (DM). The facility provided dietary schedule dated July 2024 documents that a dietary manager was scheduled on July 25, 26, 27, 28, 29 and 30. The facility provided dietary schedule dated July 2024 documents that no cook was scheduled for the evening meal on July 6, 7, 14, 16, 17, 18, 22, 23, and 24. No cook was scheduled for the morning or lunch meal on July 16, 17, 18, 23 and 24. No cook was scheduled for the morning meal on July 9, 10, 11, 15, 16, 17, 18, 20, 21, 23, and 24. On 7/29/24 at 10:47AM, V1 Administrator confirmed that the facility currently employs 2 cooks (including the dietary manager) and four dietary aids. On 7/29/24 at 8:05AM, V2 Director of Nursing arrived at the facility. On 7/29/24 at 8:10AM, V2 Director of Nursing was scrambling eggs. On 7/29/24 at 8:10AM, V2 Director of Nursing said that she was cooking because V10 and V11 dietary aids had not been trained to cook. On 7/29/24 at 8:30AM, R2 said that meals had been taking a really long time since they didn't have staff in the kitchen and that she was really hungry. On 7/29/24 at 9:00AM, R3 had not yet received breakfast. On 7/29/24 at 9:30AM, the last residents were served in the dining room. On 7/29/24 at 9:35AM, V1 Administrator said that breakfast should be served at 8:00AM. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/24 at 10:20AM, V1 Administrator said that V8 DM cooked all weekend and didn't have a dietary aid on Saturday evening. On 7/29/24 at 10:21, V1 Administrator said that V8 DM called off work today and (not having help this weekend) is probably why she isn't here today. V1 then said that he had been trying to reach V8 DM, without success. On 7/25/24 at On 7/24/24 at 1:35PM, V1 Administrator said that V4 [NAME] snapped at a resident on the night of July 13, 2024 because of resident behaviors and the fact that V4 had no help in the kitchen. On 7/29/24 at 10:30AM, V1 Administrator said that on the lack of dietary staff was impacting the residents by them being served late.