STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHELBYVILLE REHAB & HLTH C CTR	**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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on observation, interview, and record review, the facility failed to develop and implement their abuse prevention policy by failing to prevent direct access to residents by alleged perpetrators of abuse, failing to report abuse allegations to the State Survey Agency, failing to thoroughly investigate and document evidence of investigations of allegations of abuse, and failing to include the two-hour requirement for reporting abuse allegations and the prevention of audio and video recording of residents. These failures have the potential to affect all 37 residents residing in the facility. Findings include: The facility's Abuse Prevention Program Facility Policy dated 3/5/2009, provided by V1 Administrator on 3/3/20 at 1:19 pm, documents, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively; Filing accurate and timely investigative reports. Employees are to immediately report any occurrences of potential/ alleged mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Supervisors shall immediately inform the administrator or designee of all reports of potential/ alleged mistreatment. Upon learning of the report, the administrator or designee shall initiate an investigation. Employees of this facility who have been accused of mistreatment 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 mistreatment shall not complete their shift as a direct care provider to residents. Initial reporting of allegations: the Department of Public Health shall be informed within 24 hours. 1.On 3/3/20 at 9:25 am, V1, Administrator, was walking down the facility's 300 hall propelling a medication cart. V1 stated, I am the Administrator, I am also working the floor as the nurse, and the only nurse in the building. At 9:30 am, V1 stated, One allegation was recent and involved (R1), saying that I was yelling in his face. This recent allegation with (R1) was just handed to me yesterday (Monday, 3/2/20). V1 further stated, (R1) made the allegation Saturday (2/29/20) so why it didn't get any farther and get to me before Monday morning, I don't know. V1 continued, My nurses and my DON (Director of Nursing) can serve as designees for abuse reporting when I am not in the building, and I have the fax sheets for State reporting out and available, so there is no excuse for this to not have gotten reported. V1 further stated, I have not faxed a report to IDPH (Illinois Department of Public Health, State Survey Agency) yet. At 1:19 pm, V1 stated, I did investigate this allegation by asking the 3 CNAs (V7, and 2 unidentified) who were in the room with me if they thought I had been rude or abusive, and I did ask other residents if they ever had any problems with the staff, but I did all of that while I was going around the building passing (administering) medications to the residents. V1 continued, I was the only nurse in the building yesterday and today (Monday 3/2/20 and Tuesday 3/3/20) from 6:00 am until 6:00 pm, so I have been passing medications to all the residents. Should I have left the building and had my DON investigate? V1 further stated, I don't have any documentation of my investigation other than the 3 written statements I already gave you. On 3/3/20 at 11:50 am, V1 was administering medications to the residents on the 300 hall. At 12:10 pm, V1 was in the dining room during the lunch service passing medications to residents present. 2. On 3/3/20 at 9:30 am, V1 stated, There was an allegation of abuse back in January, or maybe February, again involving (R1). One of our nurses, (V25, Registered Nurse) came to me and said that (R1) had threatened to tell me that (V25) had pushed (R1) and caused (R1's) head to hit the wall. V1 further stated, I did speak to a CNA (Certified Nursing Assistant, unidentified) who was present in the shower room with (R1 and V25) who said, That didn't happen. V1 continued, (V25) was confined behind the nurses station and I went down the hall to talk to (R1), but (R1) wouldn't talk to me at the time, so my investigation was done. V1 then stated, I don't have any documentation for that allegation investigation because I talked to a witness who said it didn't happen and (R1) wouldn't say anything to me. I didn't talk to any other residents or staff. I didn't send any report to the State because (R1) wouldn't say anything to me. On 3/4/20 at 10:20 am, V25, Registered Nurse, stated, I remember (R1) saying he was going to tell (V1) I had hit (R1's) head against the wall, but I sure don't remember going to (V1) personally myself and telling her. Those events all happened on a weekend, then I was scheduled to be off work the following Monday and Tuesday. When I returned to work that Wednesday, (V1) said something to me about it so I figured (R1) must have said something about it to (V1). V1 did not provide any documented evidence for this investigation into the allegations against V25, Registered Nurse. 3. The facility's Abuse Prevention policy, provided by V1 Administrator, did not include the requirement to report allegations involving abuse within 2 hours to the administrator and the State Survey Agency (Department of Public Health), nor did the facility's policy include the prevention of audio and visual recording of residents. On 3/3/20 at 1:19 pm, V1, Administrator, stated, This is our abuse policy. The facility's Resident Roster dated 2/28/20, and Form 802 dated 3/3/20, document 37 residents reside in the facility.
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.** Based on record review and interview, the facility failed to report allegations of abuse to the Administrator and to the State Survey Agency within the required two hour time limit. This failure has the potential to affect one resident (R1) on the sample list of 12. Findings include: 1. The facility's 3 Witness Statement Forms, all dated 2/29/20, document R1 had made an allegation of verbal and mental abuse by intimidation, and named V1, Administrator, as the alleged perpetrator. These Forms specified that R1 alleged V1 had got into R1's face, was yelling at R1, pointing a finger in R1's face, told R1 that V1 is the boss and R1 will do what V1 says, and told R1 that V1 would take R1 to hell with V1. These forms also documented that V1 threatened to call R1's son/ power of attorney to report R1's unwillingness to get out of bed and go to the dining room for lunch. These forms documented that R1 was tired of being treated so badly and disrespected, and has felt unhappy ever since it happened. These statements were recorded by Certified Nursing Assistants (CNAs) V22, V23, and V24. The two Forms written by V22 and V23 were documented at 7:30 pm, while the Form written by V24 did not include a time. On 3/3/20 at 9:30 am, V1, Administrator, stated, I just got the written statements handed to me yesterday (Monday 3/2/20). (R1) reported the allegation to the 3 CNAs (V22, V23, and V24) Saturday (2/29/20), so why it didn't get any farther and get to me until Monday, I don't know. V1 continued, My nurses and my DON (Director of Nursing) can serve as designees for abuse reporting when I am not in the building, and I have the fax sheets for State reporting out and available, so there is no excuse for this to not have gotten reported. V1 further stated, I have not faxed a report to IDPH (Illinois Department of Public Health, State Survey Agency) yet. V1, Administrator, did not provide any documentation that an initial report of this allegation was sent to the State Survey Agency. On 3/4/20 at 2:44 pm, V2, Director of Nursing, stated, The Nurse (V29, Licensed Practical Nurse) working in the facility Saturday night called me at 9:52 pm to tell me that (R1) had made a

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

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) complaint about (V1) being argumentative with (R1), yelling in (R1's) face, and telling (R1) that (V1) is the boss. V2 continued, I didn't even think of it as an abuse allegation. I was thinking it was a false accusation because I know (R1) and (R1's) history of making false accusations. V2 further stated, It is on me that this didn't get reported in the 2 hour time frame. V2 concluded by stating, I did talk to (V1) about the allegations Monday morning (3/2/20) about 8:00 or 9:00 am. 2. On 3/3/20 at 9:30 am, V1, Administrator, stated, One allegation of abuse we had back in January, or maybe February, involved (R1) saying that one of our nurses (V25, Registered Nurse) had pushed (R1) against a wall and caused (R1) to hit (R1's) head on the wall. V1 then stated, I didn't document anything about this allegation or send a report to the State because (R1) wouldn't say anything to me about it. V1, Administrator, did not provide any documentation that an initial nor final report of this allegation was sent to the State Survey Agency.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Respond appropriately to all alleged violations.** Based on observation, interview, and record review, the facility failed to prevent further potential abuse while an investigation was in progress by allowing an alleged perpetrator direct, and unrestricted access to all residents in the facility, and failed to thoroughly investigate an allegation of abuse. These failures have the potential to affect all 37 residents residing in the facility. Findings include: 1. On 3/3/20 at 9:30 am, V1, Administrator, stated, We had a recent allegation of abuse concerning (R1) saying that I was in (R1's) face yelling. V1 further stated, (R1) made the allegation Saturday (2/29/20) and I found out about the allegation Monday morning (3/2/20). V1 continued, I have been working the floor as the only nurse in the building on Monday and Tuesday (3/2/20 and 3/3/20) from 6:00 am until 6:00 pm, so I have been passing medications to all the residents. The facility's 3 Witness Statement Forms, all dated 2/29/20, confirm R1 had made an allegation of verbal and mental abuse by intimidation, and named V1, Administrator, as the alleged perpetrator. R1's statements were recorded by Certified Nursing Assistants (CNAs) V22, V23, and V24. On 3/3/20 at 11:50 am, V1, Administrator, was administering medications to residents on the facility's 300 hall. At 12:10 pm, V1 was in the dining room administering medications to residents present during the noon meal service. The facility's abuse prevention policy dated 3/5/2009 documents, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences mistreatment, neglect or abuse of our residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse. Employees of this facility who have been accused of mistreatment 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 mistreatment shall not complete their shift as a direct care provider to residents. On 3/3/20 at 1:19 pm, V1, Administrator, stated, I don't have any documentation of my investigation other than the 3 written statements I gave you from the CNAs (Certified Nursing Assistants V22, V23, and V24). 2. On 3/3/20 at 9:30 am, V1 stated, There was an allegation of abuse back in January, or maybe February, involving (R1). One of our nurses, (V25, Registered Nurse) came to me and said that (R1) had threatened to tell me that (V25) had pushed (R1) and caused (R1's) head to hit the wall. V1 further stated, I did speak to a CNA (Certified Nursing Assistant, unidentified) who was present in the shower room with (R1 and V25) who said, That didn't happen. V1 continued, (V25) was confined behind the nurses station and I went down the hall to talk to (R1), but (R1) wouldn't talk to me at the time, so my investigation was done. V1 then stated, I don't have any documentation for that allegation investigation because I talked to a witness who said it didn't happen and (R1) wouldn't say anything to me. I didn't talk to any other residents or staff. I didn't send any report to the State because (R1) wouldn't say anything to me. V1 did not provide any documented evidence for this investigation into the allegations against V25, Registered Nurse. The facility's Resident Roster dated 2/28/20, and Form 802 dated 3/3/20, document 37 residents reside in the facility.