STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009369	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORVILLE CARE CENTER	600 SOUTH HOUSTON TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident Investigation IL138472 from 9/5/21.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements are not meet as evidenced by: Based on interview and record review, the facility failed to prevent an incident of mental abuse/neglect for 1 of 17 residents (R2) reviewed for abuse in the sample of 17. This failure resulted in R2 being frightened, having nightmares and afraid to use her call light.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Finding includes: R2's Face Sheet documents that R2 was admitted to the facility 8/13/21 with a primary diagnosis of a left hip fracture. R2's Minimum Data Set (MDS) dated 8/19/21 documents that R2 is cognitively intact and requires extensive assistance for toilet use. R2's Progress Notes dated 9/28/21 documents that R2 was started on an antibiotic for a Urinary Tract Infection (UTI). R2's Progress Notes dated 9/5/21 documents, "Continues on Cipro (antibiotic) for UTI with no adverse effects noted. Continues to c/o (complain of) frequency and urgency. Pyridium (analgesic) started." The Facility's Initial Incident Report dated 9/5/21 documents, "Incident Category: Abuse." It continues to document that R2 was the resident involved as the victim and that R2 is alert and oriented times 3 (cognitively intact) and is capable of communication. The report documents the staff member involved was V3, Certified Nursing Assistant (CNA) and that V3 was suspended. It further documents the detailed incident summary as, "It was reported to the administrator by (V4, Registered Nurse) that (V3) refused to take (R2) to the bathroom when (R2) requested to go." The Facility's Final Incident Report dated 9/10/21 documents the above information involving R2 and V3. The Report documents "During the interview with (R2), (R2) stated that on Sunday, (V3) came into her room to answer her call light. (R2) told (V3) that she needed the bedpan. (V3)	S9999		

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S9999	Continued From page 2	S9999		

told her she could only use it every 2 hours. (R2) told (V3) that she could not see the clock. (V3) told her she would check the clock and if it wasn't time, she would have to wait. (R2) also stated that (V3) was getting her up in the morning sooner that (than) (R2) wanted to get up. When I spoke with (V3) regarding this alleged incident, I told her she could write a statement and submit it to me. As to date, she has not made a written statement. She told me it was staff making up allegations toward her. I do not know if (V3) was being abusive intentionally, however, I do know that this is unacceptable behavior on her part, and she has been terminated. Name of person submitting report (V1, Administrator)."

A written statement, dated Sunday, 9/5/21 at 4:04 PM, written by V8, Certified Nurse's Aide (CNA) on behalf and in the presence of R2 and another staff member for a witness. The statement documents, "At 1:30 AM (V3) came in to answer (R2's) light. (R2) needed the bedpan. (V3) told her she could only use it every two hours. (R2) said she couldn't see the clock. (V3) then said she would come in here and check the clock and if it wasn't time, (R2) would have to wait. At 4:30 AM (V3) came in and told (R2) she would be back at 5:00 AM to get her up. (R2) said she didn't want to get up that early because that was too long to sit in the chair. This is not the first time (V3) has come in and told her she was to wait to use the bedpan/bathroom. (R2) is afraid to use the light because she doesn't want (V3) to come in and start in on her. (R2) claims to have peed the bed because she was afraid to use the light. (V3) also told her at her age she should be sleeping more instead of using the bathroom. (V3) has told her several times since she's been here, she has to hold it. Two weeks ago (V3) came in at about 1:30 AM and she was on the

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phone. (V3) told (R2) she had to wait until she was off the phone. (R2) says (V3) has said so much to her she can't recall all of it but every time, she is mean to her." The document was signed by V8, another CNA as a witness, and R2.

A typed statement dated 9/5/21 at 4:50 AM documents, "We went in to administer scheduled (Pain medication) to (R2) and assist her with the bedpan. (V10, Licensed Practical Nurse) asked how her night was and the resident stated, 'Not very good'. Asked her what was wrong, resident replied, 'Well I was told I had to get up right now and I would rather not. I'll be sitting up the whole day and it's a little early for me.' I informed (R2) she did not have to get up until she wants to. (R2) stated, 'Well the other girl told me that she was coming in and I had to get up.' We both assured her that she doesn't have to get up until she wants to. Resident also stated, 'She wouldn't let (me) use the bedpan when I needed to. She said I had to wait every 2 hours. I told her I couldn't see the clock. She said I'll tell you when it's time.' Resident was very upset about this." It continues to document that V10 and V11 (Licensed Practical Nurse) assured R2 that she could use the bedpan or bathroom anytime she needs and that what the CNA said was "inappropriate and wrong." It further documents that V10 and V11 assured R2 that V3 would not be back in her room and R2 stated, "Good, because I don't want her to come back in here." It further documents that at 5:50, as V3 was getting ready to leave, V10 politely told V3 that R2 does not want her in her room anymore and that someone else will have to answer her lights, to which V3 replied, "Okay, perfect." It documents that V10 texted V1, V2 Director of Nursing (DON), V13, Assistant Director of Nursing (ADON), and V14, MDS/Care Plan Coordinator. This document was signed by

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S9999	Continued From page 4 V10 and V11. An additional statement dated 9/5/21 at 5:00 PM documents, "I had been passing hall trays for lunch. I brought (R2) her tray and she told me about her night (9/4/21 overnight). Resident stated that the night shift (V3) had told her to hold her pee because she, 'Went pee too much and she needed to wait every two hours.' Resident stated she couldn't wait that she had to go now. She (the resident) had wet the bed and was still upset today (9/5/21). Resident also states that CNA woke her up at 4:30 AM to tell her she had to be up at 5:00 AM." This document was signed by V15, CNA and V16, LPN. On 9/27/21 at 2:30 PM, V7, CNA stated, " I didn't witness it (the incident between R2 and V3). I heard about it from V8. (R2) just needed help using the bed pan. It would have only taken 30 seconds to do it." On 9/27/21 at 3:56 PM, V8, CNA, stated, "I watched (V3's) hall while she was on break that night. When I answered (R2's) call light, she grabbed her chest and said, 'I'm so glad it's you!' She said she needed to talk to me and told me that (V3) was very rude to her. I told her I would definitely be reporting it. I told the nurses working and they told me to write a statement and put it under (V1's) door. I took a witness with me and wrote word for word what (R2) told me, and she signed it. I guess it wasn't the first time (V3) had treated her that way. People like (V3) don't need to be doing this type of work. (R2) told me she was scared to turn on her call light. (R2) had a UTI at the time, so she certainly shouldn't have been hold it (urine). (V3) also told (R2) she had to get up at 5 AM. (R2) was in her right mind and it's her right to not have to get up that early. (R2) told	S9999		

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S9999	Continued From page 5	S9999		

me she was having nightmares and was scared to use her call light when (V3) was working, so she just peed the bed. She always told us when she had to use the bathroom, she was continent. After I took (R2) to the bathroom I immediately told (V10) and (V11). It was about 1:30 in the morning. They passed it on to the dayshift nurses. I really did not want to leave that night, so I told the nurses to look out for her (R2). I feel like (V3) should not have been allowed to work after that. I told (V4) the next day and she told me to write the report to (V1). (V3) did finish her shift I think, but I was told (V3) would not be allowed in (R2's) room. (V3) was suspended and then they called her in and fired her."

On 9/27/21 at 4:00 PM, V4, Registered Nurse (RN) stated, "I heard that (V3) was verbally aggressive with (R2). It was out of line and inappropriate. It should not have happened. It was first reported to (V8). I heard about it in report. By the time second shift got here I had heard the whole story. (R2) had a UTI at the time and (V3) told her she would have to wait to go to the bathroom."

On 9/28/21 at 9:08 AM, V1 stated, "I would expect to be called any time, day, or night, with an allegation. If they had called me, I would have removed (V3) from patient care immediately."

On 9/28/21 at 1:00 PM, V1, Administrator stated that the incident/interaction between R2 and V3 would be considered abuse/neglect and should have never happened.

(B)