STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S 000	Initial Comments Facility Reported Incident of 1/24/25/IL185582	S 000		
S9999	Final Observations Statement of Licensure Violations 300.3210a)1) 300.3240a) Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 1) Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interviews, observations, and record reviews the facility failed to prevent verbal and	S9999		

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mental abuse for 4 out of 6 residents (R3, R4, R6, R7). This failure resulted in R3, R4, R5 and R7 experiencing psychosocial harm. Using the reasonable person concept, R3, R4, R6 and R7 experienced psychosocial harm with feelings of shame, embarrassment, humiliation or insignificance.

Findings include:

1 R3 was admitted to the facility on 1/2/2024 with diagnosis of, in part, atherosclerosis of extremities (bilateral legs), unsteadiness on feet, and unspecified displace fracture of right humerus.

R3's MDS dated 12/13/24, documents she is cognitively intact, and requires partial/moderate assistance from staff for upper and lower body dressing as well as putting on/taking off footwear.

R3's Care Plan dated 12/3/24, documents she requires assistance with activities of daily living (ADL's) related to (r/t) weakness, arthritis, history of falls, fracture of right humerus, osteoporosis and for staff to provide privacy and offer choices where available. The Care Plan continues to document R3 is at risk for falls r/t weakness, arthritis and for staff to provide a safe environment.

On 1/28/25, R3's statement for the facility's investigation on alleged abuse occurring 1/24/25, documented that V3 was inappropriate with her by not helping her get out of bed and dressed because she did not want to get dressed in the bathroom. R3 stated V3 said she couldn't help because she had to do something else.

On 2/10/25 at 9:40 AM, R3 stated V3 had treated

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her poorly a couple weeks ago. R3 stated she needed help getting up and dressed so she requested help from V3. R3 stated V3 told her she needed to get dressed in the restroom. R3 stated she told V3 she didn't want to get dressed in the restroom because there's no room but V3 told her she didn't have time and made her get dress in there. R3 stated that V3 was forceful and very rushed while putting stockings on her in the restroom, then left her in her chair to eat breakfast with just her undershirt on. R3 stated she asked V3 if she could help her put a button up shirt over her undershirt but V3 told her no, she didn't have time. R3 stated V3 left her feeling exposed and cold without her button up on.

On 2/10/25 at 9:29 AM, R2 stated V3, Certified Nursing Assistant (CNA), left a couple weeks ago and did not treat the lady next door (R3) properly. R2 stated she wouldn't have allowed V3 to take care of her family the way she took care of R3. R2 stated that V3 wouldn't allow R3 to get dressed in her room, that she needed to go in the restroom to get dressed but R3 told V3 there wasn't enough room for her in there, she would prefer getting dressed in her bedroom. R2 stated V3 preceded to make R3 get dressed in the restroom.

R2's Minimum Data Set (MDS) dated 1/20/25, documented she is cognitively intact.

V5, CNA, made a handwritten witness statement included in the facility's abuse investigation for 1/24/25. V5 ' s statement included the following: "R3 extremely upset. Stated she needed her shower, wasn't done on night shift previous day. Was still in p.j.'s (pajamas) at 9:00 AM. Stated V3 refused to do her shower or get her dressed for the day. R3 told V3 she doesn't like to get

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dressed in the B.R. (bathroom) because it's cold in there. V3 said she was going to dress her in there anyways." V5's statement continued to document, "R4 rang light this morning to get up. V3 came in with an attitude and said it's you ringing again? R4 said yes, it's me again. I ' m ready to get up. V3 told R4 okay, well you can get up by yourself. R4 was almost in tears and stated I do need help. I have one leg shorter than the other. V3 said okay, hurry up, I don't have all day." V5's statement also included, "R2 stated instead of working this morning, V3 was in the hallway complaining all morning about how this hall needs two people and she wasn't doing any showers. Residents ring and she doesn't answer the lights in a timely manner or when fall alarms go off she doesn't come to answer them. Has a very off-putting attitude."

2. R4 was admitted to the facility on 10/28/2009 with diagnosis of, in part, heart failure, chronic obstructive pulmonary disease, hemiplegia and hemiparesis.

R4's MDS dated 1/6/25, documented she is cognitively intact and requires partial/moderate assistance with all transfers.

R4's Care Plan dated 1/14/25, documented she requires assistance at all times with ADL's r/t weakness, knee pain, unsteady balance and for staff to provide one assist with transfers and does not ambulate at this time. (R4 is afraid of falling when ambulating r/t history of fractures from fall).

The facility's investigation for the alleged abuse occurring on 1/24/25, documented R4 stated she needs help getting out of bed and V3 asked R4 why she can't do that herself. R4's statement continued to say she told V3 she would if she

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could.

On 2/10/25 at 9:45 AM, R4 stated V3 left a couple weeks ago; she was rude. R4 stated she told V3 she needed help getting up and V3 told her she can do it herself and refused to help her. R4 stated she continued to ask V3 for help until she finally gave in to help her. R4 stated V3 made her feel terrible. R4 stated she reported V3 to V1, Administrator, and V1 told her she would take care of it, soon after, V3 was gone and did not work at the facility any longer.

On 2/10/25 at 9:50 AM, V2, CNA, stated V3 was the impatient type of person and wasn't sure if she should have been helping people with dementia.

3. R6 was admitted to the facility on 1/5/25 with diagnosis of, in part, Alzheimer's disease with early onset, hypertension and epilepsy.

R6's MDS dated 2/7/25, documents she requires set-up and clean-up assistance with dressing. R6's MDS indicated R6 is not interviewable.

R7 was admitted to the facility on 5/28/23 with diagnosis of, in part, congestive heart failure, Alzheimer's disease and vascular dementia.

R7's MDS dated 12/30/25, documented he requires supervision/touching assistance from staff for toileting transfers and substantial/maximal assistance for toileting hygiene. R7 MDS indicated R7 was not interviewable.

On 2/10/25 at 9:49 AM, R5 stated she had witnessed V3 treat other resident's poorly before she stopped working at the facility. R5 stated she

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heard V3 yell at R6 because R6 walked out of her room without getting dressed in the clothes she laid on her bed. R5 stated R6 needed assistance getting dressed, she has some sort of dementia and doesn't do that by herself. R5 stated she heard V3 also yell at R7 because he peed on the floor and she slipped in it. R5 stated R7 had an accident, he couldn't help it and it was wrong for her to treat him that way. R5 stated she wanted to have a come to Jesus talk with V3 because of the poor way she treated the other residents, she couldn't believe the way V3 was treating them, it was horrible. R5 stated she reported to V3, to V1, Administrator and she started an investigation, shortly after, V3 did not come back to work.

R5's MDS dated 12/5/24 documented she is cognitively intact.

The facility's investigation for alleged abuse occurring on 1/24/25, documented R5 stated she heard V3 tell the resident next door (R7) with a raised voice, "You peed on the floor and I almost slipped and fell." R5's statement continued to document she heard V3 yelling at R6, "I laid you out clothes, why did you come out without changing them?"

The facility's investigation on the alleged abuse allegations occurring on 1/24/25 documented that it was verified V3 engaged in behaviors that constituted abuse or neglect.

On 2/10/25 at 1:20 PM, V1, Administrator, stated she was notified of concerns involving V3 by V5 on 1/24/25. V1 stated she does not expect any of her staff to be treating the resident's the way V3 was. V1 stated V3's behavior and actions were inappropriate, and she was terminated following her investigation.

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S9999	Continued From page 6 The facility's Abuse Policy dated 1/12/17, documented, "It is the policy of this facility to provide each resident with an environment that is free from any type of abuse, neglect or misappropriation of property. Each resident has the right to be free from exploitation, verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The policy defined abuse as, "The will infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain, or mental anguish; or deprivation by an individual, mental, and psychosocial well-being and includes verbal abuse, sexual abuse, physical abuse and mental abuse. Mental abuse is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services." (B)	S9999		