STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN OF MEADOWBROOK	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

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S 000	Initial Comments Annual Certification Survey First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 300.1210b) Section 300.3210a)1)2)A)B) Section 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 300.3210 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	S9999		

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S9999	Continued From page 1	S9999		

in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities.

2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team.

A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality.

B) A facility shall protect and promote the rights 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.
Based on observation, interview, and record review the facility failed to respect residents' right to be treated with dignity and respect for seven (R10, R31, R19, R29, R37, R45, R57) of seven residents reviewed for resident rights in the sample list of 39. This failure resulted in psychosocial harm of R10 and R57 causing R10 and R57 to be visibly upset and tearful.

Findings include:

The undated Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities documents

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S9999	Continued From page 2 "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life." 1.) The facility's Resident Council Minutes dated 9/19/24 document call lights need answered timely and Certified Nursing Assistants (CNA) say "not my resident" when asked to provide care or answer call lights for unassigned residents. The facility's Resident Council Minutes dated 10/17/24 document concerns with CNAs and Nurses needing "attitude adjustments" and using phrases "not my job, not my resident." The facility's Resident Council Minutes dated 11/21/24 document concerns that kitchen staff refuse things when asked. The facility's Resident Council Minutes dated 12/20/24 document the CNAs need "attitude adjustments" and concerns with CNAs being on their cellular phones and not answering call lights timely. The Resident Council Minutes dated 2/20/25 document concerns with CNA, nurses and dietary staff needing "attitude adjustments," and residents have to call the nurse's station due to call lights not being answered. On 3/09/25 at 2:07 PM a resident council meeting was conducted. R29, R57, R37, R19 and R45 all confirmed call light wait times have been an ongoing problem with call lights being on for 45 minutes to an hour. R29 stated R29's main concern is that CNAs say "I'll be right back" or "I'm not your CNA." R57 stated the CNA attitudes are "atrocious" and all residents agreed staff attitudes have been an ongoing problem. R29 and R57 stated when the residents complain about staff, the staff then intentionally don't answer their call lights, but were unable to identify which staff. R37 stated about a month ago R37 fell on the floor in his bathroom and waited for an	S9999		

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hour and half with the call light on. R37 stated no staff came to answer R37's call light so R37 had to self transfer off of the floor and R37 reported this to unidentified staff. R29 stated V9 Cook had R57 in tears yesterday because R57 asked what the alternative was for dinner. R57 stated V9 said "it's soup and sandwich" and then V9 turned to an unidentified coworker and said V9 was "tired of this" and V9 was ready to clock out and go home. R57 stated staff, including V16 CNA, witnessed this incident. R57 stated R57 didn't feel V9's actions were considered abuse but more of a dignity and respect issue. R57 stated R57 felt "scolded like a child." R29, R57, R37, R19 and R45 all stated V9 has a terrible attitude and tells the residents "take it or leave it" when it comes to the food. These residents also stated V13 CNA is always on V13's phone, V13 is rude, V13 has an attitude and tells residents that V13 will "be right back" but then doesn't return to answer the call light.

On 3/10/25 at 2:28 PM V16 CNA stated V16 witnessed the incident between R57 and V9 that occurred in the evening of 3/8/25. V16 stated R57 wanted to know what food was being served and V9 "fired off at (R57)" and was rude to R57. V16 stated V9 said R57 was getting on V9's nerves and V9 was ready to clock out and go home. V16 stated at that time R57 was upset/tearful and R57 didn't want anything to eat. V16 stated V16 reported this immediately to V1 Administrator.

On 3/10/25 at 10:41 AM V12 CNA stated V9 is short with the residents, V9's tone is loud, and V9 does not always get the residents the foods that they request from the kitchen.

On 3/10/25 at 2:09 PM V1 Administrator stated V1 had not been made aware of any concerns

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with V9's and V13's attitudes or dignity/respect. V1 stated V1 will need to follow up and do customer service education. On 3/11/25 at 10:37 AM V1 stated the dignity is part of the Resident Rights packet, which is what the facility uses as a policy.

2.) On 3/09/25 at 9:51 AM R31 stated CNAs (later identified as V16 and V15) got mad at R31's room mate, R10, causing R10 to cry. R31 stated R31 reported this to V8 Social Service Director who said V8 would follow up with V1 Administrator. R10 stated sometime last week the CNA (V16) came in to assist R10, this CNA was upset because night shift had not changed R10 or applied R10's lymphedema compression machine to R10's legs. R10 stated the CNA said night shift should have already applied R10's compression machine and changed R10. R10 told V16 that R10 was "disgusted" and V16 told R10 "well it's my job." R10 stated the CNA caused R10 to cry, "like I'm (R10) going to now." R10 was visibly upset and tearful. R10 stated R10 didn't feel abused by V16, but that it was more of a dignity/respect issue. R10 stated it was V16's tone of voice and R10 felt "scolded" by V16.

R31's Grievance/Complaint Form dated 3/6/25 documents R31 reported the CNAs came in very early to wake up R10, the CNAs were loud and upsetting R10 while they assisted R10 out of bed. R31 had asked the CNAs why R10 had to get up so early and they replied that they had to, which caused R10 to be very upset.

On 3/09/25 at 11:59 AM V8 stated on 3/6/25 R31 reported concerns that the CNAs had upset R10. The CNAs were complaining because R10 and R31 were complaining about getting up so early. V8 stated the CNAs told R31/R10 that was what

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S9999	Continued From page 5 they had to do. V8 stated this was reported to V1 on 3/7/25. On 3/10/25 at 10:41 AM V16 CNA recalled the incident with R10. V16 stated night shift had not completed their assigned tasks for R10 one day last week which caused more work for the dayshift. V16 stated V16 was frustrated and should not have vented to R10 because R10 took it personally. V16 stated R10 was upset/crying and V16 reassured R10 and apologized at that time. On 3/10/25 at 2:09 PM V1 stated V1 had not been made aware of any concerns with V15's and V16's attitudes or dignity/respect. B	S9999		