STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000996	A. BUILDING: ______ B. WING ______	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON REHABILITATION & HCC	1925 SOUTH MAIN STREET BLOOMINGTON, IL 61701

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S 000	Initial Comments Complaint Investigation 2363152/IL158782	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3220d) 300.3240a) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 300.3220 Medical Care

d) Every resident shall be permitted to participate in the planning of his or her total care and medical treatment to the extent that his or her condition permits. (Section 2-104(a) of the Act)

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).

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were Not Met as evidenced by:

Based on interview and record review, the facility failed to ensure a resident was free of physical and verbal abuse for one of three residents (R1) reviewed for abuse on the sample list of five. This abuse caused R1 to become tearful and start

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refusing cares due to the humiliation.

Findings include:

On 4/19/23 at 9:20 am, V21 (R1's family) stated facility staff will call R1 a baby, shame R1 for being incontinent, and tell R1 that R1 is gross, to the point R1 is in tears. V21 explained V2 (Director of Nursing/DON) told V21 that V2 had went in to clean R1 up one time and that it was "gross," R1 had dried bowel movement dried onto (R1) to the point where V2 had to throw hot water on R1 to loosen it, which is odd because (R1's) room didn't have any hot water, only cold water." V21 stated, "I (V21) know it is gross cleaning up bowel movement, but that is their job. (R1) shouldn't be humiliated and talked down to for being incontinent." V21 explained that because of how staff treated and talked down to R1, R1 started refusing cares.

On 4/19/23 at 11:49 am, V1 (Administrator) stated V1 has not had any abuse allegations in the past three months.

On 4/20/23 at 11:30 am, V6 (Certified Nursing Assistant/CNA) stated V6 overheard V2 DON be verbally/mentally abusive toward R1 and explained that last week, R1 had a doctor's appointment and wasn't wanting to go because of being uncomfortable. V6 stated R1 is a "bigger man and was in a lot of pain, and really didn't fit into the wheelchair appropriately; R1 sits kind of sideways in there, and R1's stomach was pressed up against the arm of the wheelchair." V6 stated there were two wheelchairs in the room and V9 (Registered Nurse/RN) was trying to figure out which one to put R1 into, so V9 called V2 (DON) down to talk with R1 and try to figure out a chair that was comfortable for R1, and that

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is when V2 "started yelling at R1 telling R1 that (R1) had to go to the doctor because R1 skipped last week's appointment and to stop being a crybaby." V6 stated V6 was walking by the room when V6 overheard the yelling, but at this point, R1 was "crying and visibly upset."

On 4/20/23 at 12:59 pm, V2 (DON) denied ever yelling at R1 or calling R1 a crybaby and stated "I (V2) would never do that." V2 confirmed V2 was involved in the wheelchair situation with R1 and explained V2 had told nursing staff, "don't recall who", the day prior the R1's appointment that they needed to get R1 fitted for a more comfortable wheelchair as R1 was scheduled for a neuropsychiatric appointment and needed to go, and that R1 hadn't been wanting to get up due to being uncomfortable in the wheelchair. V2 also confirmed V2 spoke with V21 (R1's family) one night and had reported to V21 about having to soak towels in water to get the bowel movement off of R1 but "I (V2) never said I (V2) threw hot water on R1." V2 explained R1 had dried feces on R1, all the way down to R1's knees because R1 had refused to be cleaned up twice before, so V2 went in to assist staff with cares for R1. V2 explained that V2 and two CNAs (Certified Nursing Assistants) ended up having to soak towels in water with a cleaner and lay them on R1 to get the feces loose so that it could be cleaned off because when we were trying to get R1 clean, R1 was saying we were hurting R1.

R1 has been away from the facility since 4/12/23 as confirmed on 4/20/23 at 9:50 am, V10 (Business Office Manager/BOM) and unable to be interviewed.

R1's ongoing facility abuse investigation of 4/20/23 contains several witness statements that

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document the following:

V6's statement - V9 (RN) was the nurse on duty and had gotten R1 up into one of the wheelchairs in R1's room. R1 was uncomfortable, stating the wheelchair was uncomfortable because it was too small for R1. V9 went to get V2 to see which chair R1 should be in and as soon as V2 entered the room, it was "instant yelling; these are the two chairs you have! You picked these! You're going to your appointment. You missed your last psych eval because you were being a cry baby." At this point, R1 replied "it's because I'm in pain." V6 documents that V2 responded with "I (V2) do understand, but this isn't an option. You're going to this appointment." V6 documents V6 did not report V2 yelling at R1 because V9 was in the room and heard it and because V2 was acting as the Abuse Coordinator due to V1 (Administrator) being off of work. V6 also documents V6 has not seen or heard about V2 throwing hot water on R1, but that V2 had admitted to dumping tubs of water on resident's when doing bed baths and chuckling about it.

V14's (CNA) statement - V2 was very adamant about V14 putting R1 into another resident's wheelchair which V14 told V2 that the chair was too small for R1. V2 told V14 that R1 "had no choice" because the one from the day before hurt R1 too. V14 and another CNA got R1 cleaned up and transferred R1 into the chair. V14 don't know what happened after that as V14 left the room but explained that R1 told V9 that R1 was still uncomfortable in the wheelchair, and that is when V9 brought V2 into the room. V2 came in "guns a blazing" and said "you're going to this appointment; you missed your appointment the day before. You only have this chair or that chair to get in." V2 kept cutting R1 off and wouldn't let

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R1 talk, and R1 was only trying to tell V2 that the chair was too small. V2 told R1, "you're being a big baby right now." V14 documented V14 has not heard V2 yell at any other residents but that V2 doesn't talk to them with respect. V14 also documented V14 has heard about V2 throwing hot water on a resident and had seen it "back in the day", V2 dumps basins of water on them while in their beds to give them bed baths.

V16's (CNA) statement - V16 came into work on the day in question at 10:00 am and R1 had been incontinent of stool. V2 had found R1 with dried bowel movement all the way down R1's legs. V2 yelled for V16 to come down to R1's room and V2 said R1 needed changed. V2 had a basin filled with water and V2 told V15 (CNA) who was also in the room, that V2 was going to dump in on the bed and get R1 cleaned up that way, but V2 dumped the basin of water on R1 and R1 yelled. V16 doesn't know if it was hot or cold water as V16 never touched the water. V2 then had V15 turn R1 over, and V2 started scrubbing the stool off of R1 and then left the room for us to finish.

On 4/23/23 at 11:48 am, V15 (CNA) stated V15 don't know if R1 refused cares the morning in question or not as V15 had just arrived on duty but explained that R1 did have a history of refusing cares. V15 stated R1 had dried bowel movement, and V2 was already in the process of cleaning R1 up. V15 explained that V15 didn't see V2 dump water on R1 however the bed was pretty wet with water.

On 4/24/23 at 11:59 am, V1 (Administrator) stated the abuse investigation is still going on, but from what V1 is being told, V1 considers V2's actions to be abusive.

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S9999	Continued From page 6 The facility Abuse Prevention Program dated 11/28/2016 documents the facility prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. This facility is committed to protecting our residents from abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse is 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. Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. (B)	S9999		