| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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<br><br>Annual Licensure Survey<br><br>Investigation of Facility Reported Incident of October 26, 2023/IL166369 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.690a)<br>300.690b)<br>300.690c)<br>300.3210t)<br>300.3240b)<br>300.3240c)<br>300.3240g)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.690 Incidents and Accidents<br>a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 1<br>affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.<br><br>300.3210 General<br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.<br><br>Section 300.3240 Abuse and Neglect<br>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 2<br>3-610(a) of the Act)<br><br>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>A. Based on observation, interview, and record review the facility failed to identify repeated episodes of verbal abuse of R28 by V11 (R28's Spouse) and failed to protect the resident's right to be free from verbal, mental, and physical abuse by V11. These failures resulted in V11 being allowed unsupervised visits with R28, subjecting R28 to repeated incidents of verbal and mental abuse by V11, and R28 being hit in the mouth by V11 resulting in psychosocial harm. R28 is one of five residents reviewed for abuse in the sample list of 33.<br><br>B. Based on interview and record review the facility failed to ensure repetitive allegations of verbal and mental abuse and an injury of unknown origin were reported to the administrator, and timely report an allegation of abuse to the state survey agency. These failures affect two (R28, R45) of five residents reviewed for abuse in the sample list of 33. These failures resulted in R28 being subjected to repeated incidents of verbal/mental abuse, and physical | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 3<br>abuse by V11 (R28's Spouse) resulting in psychosocial harm for R28.<br><br>Findings include:<br><br>The facility's Abuse Prevention policy revised 11/28/16 documents: "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below." "The facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents." "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." "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." "Mental Abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), harassment, or humiliation and threats of punishment or deprivation." "Physical Abuse including hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." "Employees are required to | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property to a supervisor and administrator." "Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property." "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries, of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee."

1.) The Facility Reported Incidents report form dated 10/27/23 at 5:27 PM documents on 10/26/23 V9 (Visitor) reported that V11 was feeding R28, R28 refused and pushed V11's hand away, and V11 hit R28 in the mouth. The facility's (State Surveying Agency) Notification Form dated 11/1/23 documents the incident between V11 and R28 occurred on 10/26/23 at 6:50 PM. This form documents the facility found no intentional abuse on V11's part. The facility instructed V11 not to feed R28 again, the staff will feed R28, and V11 was educated on Dementia and R28 not wanting to eat.

The Incident Investigation Form dated 10/26/23 at 10:00 PM documents V2's (Director of Nursing/DON) interview. V2 was approached by V9 who reported that V11 struck R28 in the mouth with V11's hand at the dining room table, and V11 was swearing at R28. V2 immediately

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

approached V11 and R28. V11 stated "(R28) won't eat. (R28) don't got a brain in (R28's) head." V11 continued to belittle R28. V11 and R28 were separated. V11 went home. V2 asked R28 where V11 hit R28, and R28 pointed to R28's mouth. R28 had no signs of injury or pain.

The Incident Investigation Form dated 10/27/23 at 9:45 AM documents: V1 interviewed V10 (Visitor), V10 witnessed V11 feeding R28 in the dining room, and R28 kept moving R28's head back not wanting to eat. R28 pushed V11's hand away and V11 hit R28 in the mouth and told R28 "if you don't want to (expletive) eat, you (R28) can starve."

The Incident Investigation Form dated 10/30/23 at 12:05 PM documents V1 interviewed V9 regarding the incident, and V9 stated that V9 witnessed V11 trying to force R28 to eat while R28 kept tilting R28's head back. It looked like V11 had food in V11's hand and was holding it up to V11's mouth. R28 said "No, no I (R28) don't want it" and V11 kept trying to feed R28. V11 then hit R28 in the mouth with V11's fist. V9 yelled out for V11 to stop and V9 sent V17 (Visitor) to get a nurse.

The Incident Investigation Form dated 10/27/23 at 11:30 AM documents: V1 interviewed V11 regarding the incident, V11 denied hitting R28 and V11 said V11 was trying to feed R28 a cookie. V11 stated V11 might have cursed at R28. V11 said R28 is going to starve and V11 just wants R28 to eat, and R28 has not been the same since R28 fell at home and broke R28's hip. V1 tried to explain Dementia to V11 and will provide V11 with additional support. V1 asked for V16 (R28's Power of Attorney) to come to the facility with V11 after the investigation and put a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 6<br>plan in place to keep R28 safe while V11 visits.<br><br>The Incident Investigation Form dated 10/27/23 at 2:00 PM documents: R28 was interviewed by V4 (Social Services Director). R28 was asked if R28 could remember V11 visiting the night before. R28 replied yes. R28 was asked if R28 could tell V4 what happened and R28 did not answer. R28 was asked if V11 "hollered" at R28 and R28 replied yes. R28 was asked if V11 hit R28 and R28 said no, that V11 "fell on (R28)." R28 was asked if V11 hit R28 at home and R28 replied "yes all the time". R28 stated "He has been hitting me since I was a little girl."<br><br>The Incident Investigation Form dated 10/31/23 at 9:15 AM documents the Interdisciplinary Team reviewed the incident and agreed that V11 can continue to visit, but V11 is not to feed R28 during V11's visits.<br><br>V1 (Administrator) provided the facility's undated abuse log that was requested for September-November 2023. There is no documentation of abuse allegations involving V11 and R28 besides the incident on 10/26/23.<br><br>On 11/05/23 at 2:40 PM V1 stated the initial report to the state survey agency for the incident on 10/26/23 was not sent in until 10/27/23. V1 stated it was a miscommunication and V1 thought V2 had submitted the report. V1 stated the time frame for reporting abuse allegations to the state survey agency is two hours. On 11/06/23 at 11:06 AM V1 stated during a morning meeting, V3 mentioned that V3 had spoken to V11 about V11 getting overwhelmed with R28 not eating. V1 stated nothing was brought up about V11 being abusive to R28. V1 confirmed calling a resident an idiot, stupid, moron would be considered | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

verbal abuse. V1 stated if staff had reported these prior incidents, V1 would have initiated investigations into V11's interactions with R28 just like the incident on 10/26/23, suspend V11's visits during the investigations, restricted V11 from feeding R28, and V1 possibly would have implemented supervised visits for V11 and R28.

R28's Admission Minimum Data Set dated 9/27/23 documents R28 has severe cognitive impairment. R28's November 2023 Physician Order Summary documents R28 has Dementia. R28's medical record does not contain a comprehensive care plan to address R28's risk for abuse or incidents of abuse from V11. There is no documentation that the facility implemented increased supervision of R28 during V11's visits.

V11 and R28 were in R28's room unsupervised and without staff present on 11/05/23 at 11:00 AM and 11:40 AM, on 11/6/23 at 9:43 AM, 9:58 AM, 10:00 AM, 10:15 AM, 11:03 AM, and on 11/7/23 at 10:48 AM.

On 11/06/23 at 9:15 AM V7 (Certified Nursing Assistant/CNA) stated V11 and R28 are "hateful towards each other" and this was prior to the incident on 10/26/23. V7 stated V11 is no longer allowed to feed R28, and V11 visits with R28 in R28's room or in the dining room without staff supervision.

On 11/6/23 at 9:22 AM V8 (CNA) stated V11 has been frustrated with R28 while feeding R28. V11 has called R28 "stupid, idiot, moron" and R28 was tearful. V11 stated this used to happen daily during V11's visits prior to the physical abuse of V11 hitting R28 in the mouth. V8 stated R28 has told V8 that R28 and V11 have been together since R28 was 16 and that V11 has "always been

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 8 | S9999 | | |

that way." V8 stated the incidents have occurred on second shift. V8 stated V8, V18 (CNA), and a few other unidentified CNAs on second shift have reported the incidents to V3 (Assistant DON) on several occasions and was told that V11 had been spoken to. At 10:39 AM V8 stated abuse allegations are reported immediately to V1 and usually V1 is gone in the evenings. V8 stated V3 was working in the facility when the incidents occurred, which is why V8 reported to V3. V8 confirmed V8 specifically told V3 the names that V11 called R28. V8 confirmed V8 did not report the incidents to V1.

On 11/06/23 at 9:48 AM V9 stated during supper on 10/26/23 R28 was sitting at a table that was directly in front of (family member's) table where V9 was sitting, and V9 had a clear view of R28 and V11. V9 stated R28 moved R28's head back multiple times while V11 fed R28. V9 heard R28 say "stop, stop, I don't want it." V9 stated V9 then witnessed V11 pull V11's hand back, there was no food in V11's hand, and V11 hit R28 in the mouth with V11's closed fist. V9 stated V9 told V11 to stop and sent V17 to get a nurse. V9 stated V17 did not witness the incident. V10 was also present and may have witnessed the incident. V9 stated there was no staff present in the dining room during the incident. V9 stated V11 said that R28 was worthless, made belittling comments, and said "you're stupid" to R28. V9 stated "it was very mean what (V11) did to (R28)." R28 was just quiet and did not say anything back to V11. At 1:03 PM V9 stated V9 did not know R28 or V11 prior to their family member being admitted to the facility. V9 stated V9 does not know V11 and R28 personally.

On 11/06/23 at 10:10 AM V18 (CNA) stated prior to that night (10/26/23) on multiple occasions,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 9 | S9999 | | |

almost every night V11 would feed R28, call R28 stupid, yell at R28 and degrade R28. V18 stated R28 would cry or go silent in response to V11's actions. One night V11 asked R28 why R28 was crying and R28 stated "because you (V11) yelled at me (R28)." V18 stated "it was verbal abuse the way (V11) treated (R28)." V18 stated V19 (CNA), V25 (CNA), V26 (CNA), and V27 (Unit Aide) have also witnessed these interactions as well. V18 stated V18 reported V11's actions to V3 (Assistant DON). V3 said V3 would talk with V1 (Administrator), and V3 later told V18 that V1 was made aware. V18 stated V18 asked V3 about separating V11 and R28 and was told that V11 is R28's spouse who pays for R28 to live in the facility. V18 stated V18 never spoke with V1 regarding V11's interactions with R28.

On 11/06/23 at 3:32 PM V19 (CNA) stated when V11 would feed R28, V11 would raise V11's voice at R28 and call R28 "ignorant" and "stupid". V19 stated it happened often, and confirmed the incidents were prior to the 10/26/23 incident. V19 stated R28 would get upset and ask V11 why V11 was talking to R28 like that. V19 confirmed V19 did not report the incidents to V1.

On 11/06/23 at 10:29 AM V3 was asked about V11's interactions with R28. V3 stated "there are constant issues" and V11 gets frustrated with R28 not wanting to eat. V3 stated unidentified staff mentioned in general to V3 that V11 would get frustrated and general concerns with how V11 would speak to R28. V3 stated V3 reminded V11 to be mindful of how V11 spoke to R28. V3 stated V3 discussed during the morning interdisciplinary team meetings to pay attention to V11's interactions with R28. V3 stated V3 would have reported immediately to V1 if staff told V3

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 10<br>that V11 called R28 names such as idiot, stupid, or moron.<br><br>On 11/6/23 at 10:44 AM V2 (DON) stated the night of the incident V17 reported to V2 that V11 was trying to force food into R28's mouth, R28 wouldn't eat, and V11 hit R28 in the mouth. V2 witnessed V11 say, with R28 present, that R28 doesn't have a brain, in reference to R28 not eating. V2 described V11 as being really frustrated that R28 would not eat, and R28 was sitting there with R28's eyes closed. V2 stated V2 asked R28 where V11 hit R28, and R28 pointed to R28's mouth. V2 stated V9's family member has only been in the facility for about a week, and V2 has no reason not to believe V9's description of the incident. V2 stated nothing had been reported previously about V11's treatment of R28. V2 stated V2 has not been attending morning meetings due to working night shift.<br><br>On 11/06/23 at 11:06 AM V1 stated during a morning meeting, V3 mentioned that V3 had spoken to V11 about V11 getting overwhelmed with R28 not eating. V1 stated nothing was brought up about V11 being abusive towards R28. V1 confirmed calling a resident an idiot, stupid, moron would be verbal abuse. V1 stated V1 would have initiated investigations into V11's interactions with R28 just like the incident on 10/26/23, suspended V11's visits during the investigations, restricted V11 from feeding R28, and V1 possibly would have implemented supervised visits for V11 and R28. V1 stated V1 interviewed V10 and V10 witnessed V11 trying to make R28 eat, as R28 moved R28's head away (V11) "went like this", and V1 demonstrated a close fist touching her mouth. V1 confirmed V10 reported hearing V11 say "you (R28) can (expletive) starve then." V1 stated V11 told V1 | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING: _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 11 | S9999 | | |

that V11 may have cursed at R28 but did not hit R28. V11 reported that V11 had a piece of a cookie pushed up against R28's mouth. V1 stated V1 interviewed V9 and V9 told V1 that V11 kept trying to feed R28, R28 did not want to eat, and V11 hit R28 in the mouth. V1 stated abuse was not substantiated; the incident was discussed with the interdisciplinary team, and it was decided that V11 is no longer allowed to feed R28. V1 confirmed the facility has not implemented supervised visits for V11 and R28 after the 10/26/23 incident.

On 11/07/23 at 9:52 AM V16 (R28's Power of Attorney) stated R28 has Dementia, and this has affected R28's ability to recognize hunger. V16 stated V16 has tried to explain that to V11, but V11 thinks R28 will get better and return home. V16 was asked prior to R28's dementia, how would R28 have felt or responded to V11's verbal treatment and being hit in the mouth in front of other residents and visitors. V16 stated R28 would have yelled back at V11. V16 was asked if R28 would have felt humiliated, embarrassed, upset, or tearful and V16 replied R28 would have probably felt all those things.

2.) R45's Physician's Order Sheet (POS) for November 2023 includes the following diagnoses: Dementia with Behavioral Disturbance, Depression, Anxiety, Insomnia, and History of Fall with Hip Fracture.

R45's Minimum Data Set (MDS) dated 7/11/23 documents R45 is severely cognitively impaired, is wheelchair bound, and requires moderate to maximum staff assistance to complete Activities of Daily Living (ADLs).

R45's skilled nurse's note date 6/18/23 at 7:15AM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004824 | A. BUILDING _____ B. WING _____ | 11/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FARMER CITY REHAB & HEALTHCARE | 404 BROOKVIEW DRIVE FARMER CITY, IL 61842 |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 12<br><br>documents "Noted Bruising on (R45's) left hand that extends up to forearm. Area measures 21 centimeters by 14 centimeters. Purple and black in color. (R45) denies pain or discomfort. (R45) is unsure how (R45) obtained bruise. Staff will monitor for changes until resolved. Nurse Practitioner notified and family notified. Power of Attorney voiced understanding."<br><br>R45's skilled nurse's note date 6/19/23 at 3:10PM documents CNA advised writer about large hematoma and bruising to left wrist. Writer observed (R45) to have a golf ball sized hematoma to left wrist and bruising covering most of the arm to the elbow. Resident complains of pain to the hematoma. Will advise day nurse to get X-ray orders from Nurse Practitioner. Writer attempted to apply ice pack. (R45) refused and wouldn't leave ice pack on.<br><br>On 11/6/23 V1 (Administrator) stated "I've checked with (V2) the Director of Nursing and this injury was not reported. We do not have an investigation for an injury of unknown origin."<br><br>"B" | S9999 | | |