STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F 458 SS=C	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide 80 square feet of space per resident in multi-resident bedrooms located on 3 of 4 resident living corridors. The finding is: Review of historical room size documentation indicates that 32 two- bed rooms on the 100, 200, and 300 halls do not provide at least 80 square feet of space per resident. The following bedrooms provide only 73 square feet per resident: 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 201, 202, 203, 204, 205, 206, 207, 208, 209, and 210. The following bedrooms provide only 78 square feet per resident: 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, and 311. All of the undersized rooms are Medicaid (Title 19) Certified. During resident Quarterly Care Plan conferences, the size of the resident rooms are assessed to meet the needs of the residents	F 458		8/31/09
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.695a)2)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 23 300.695b)2) 300.695c)1)2) 300.1210a) 300.3240a) 300.3240f) Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 2) Physical abuse b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident; Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. Adequate and properly supervised	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 24 nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures: 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to identify R14's willful act of assault on R15 as an act of abuse. R14 and R15 are 2 of 4 residents sampled for abuse. The facility failed to protect 1 of 1 assault victim (R15) from potential further abuse following a witnessed resident to resident attack carried out by R14. Findings include: A facility "Quality Care Reporting Form" dated 8-7-09 documents that R14 "assaulted another resident" at 4:10 p.m. The report states that the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 25 incident was witnessed by E3, Registered Nurse who reported the incident at that time to E1, Administrator who was present in the building at the time of the occurrence. The report states that the perpetrator, R14, was provided "counseling by (E3) & (E1)" and was "removed from the area." The report further indicates that R14 was "on 15 min. (minute) behavior checks." A facility "Quality Care Reporting Form" dated 8-7-09 documents that R15 was "assaulted by another resident" at 4:10 p.m. The report states that the incident was witnessed by E3, Registered Nurse who reported the incident at this time to E1, Administrator who was present in the building at the time of the occurrence. The report states that R15 was assessed with no injuries and was "removed from situation/area." R15's nurse's notes dated 8-7-09 at 4:10 p.m. state "(R15) was sitting calmly in (wheelchair) in (dining room) near another res (resident) table. Other res approached this res from behind said nothing at first. Put this resident in a choke hold, stood up from his w/c (wheelchair) & began punching this res in head then began yelling @ (at) him. Writer (E3) ran from nurse's station over to area and separated residents...." R14's nurse's notes dated 8-7-09 at 4:10 p.m. state "resident approached another resident in DR (dining room). Other resident was sitting in wheelchair near this resident table. This resident got other resident in choke hold and proceeded to repeatedly punch other resident in the head--then began yelling at him. Writer (E3) ran from nurse's station over to area and resident sat back down in wheelchair. Other residents immediately removed from area and assessed	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 26 (with) (no) injury noted. Returned to this resident and questioned. States "he was in my spot." Asked if resident asked other resident to move--states "no I just attacked him--he made me mad." Administrator here and aware. Resident returned to room and administrator went to speak (with) him. Resident is currently on 15 min behavior checks. Will continue to monitor." R14's nurse's notes dated 8-7-09 at 5:15 p.m. states "resident (return) to Dining Room. Asked for cheese sandwich & saltines & milk. Kitchen staff serving trays and informed resident that they would make a sandwich. Resident became angry, yelling, and wheeled himself back down to his room yelling he "didn't want to wait." A 9:40 p.m. nurses note states "no further behaviors." R14 stated on 8-18-09 at 2:00 p.m. that he had recently been in a physical altercation with R15 in the dining room. R14 stated that "it was close to supper time" and that he had informed R15 that he was occupying his dining table spot. R14 stated that R15 refused to move and uttered an expletive to R14. R14 further stated that R15 threatened to "blow my head off with a gun." R14 stated that he then "grabbed him by the nose and put his head down to his knees to see if he had a gun or knife or anything." R14 stated that staff (E3 and E1) then "pulled me away from him." R14 stated that immediately following this incident R15 "calmed down" and "I went on about my business." During the discussion with R14 about the incident he denied hitting R15. R14 stated that this was not the first time that R15 had threatened him. R14 stated that he was not scared of R15 but "concerned." R14 stated that he was in the special forces in the Army and was trained to "apply immediate action" and did so.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 27 An undated Incident Investigation Form completed by E1 states that E1 spoke to R14 in his room following the incident. E1 documented that R14 denied hitting R15 and asserted that R15 had threatened him by stating he "was going to shoot him with a gun when (R14) went into the dining room for supper." R14 related to E1 in the document that he had "pushed his nose down making sure he did not have a gun." E1 stated in interview on 8-18-09 at 2:40 p.m. that R14's assault on R15 on 8-7-09 was not viewed as abuse but rather viewed as a behavior. Interviews with E11, Licensed Practical Nurse, on 8-19-09 at 12:40 p.m. and E3, Registered Nurse on 8-19-09 at 2:20 p.m. reflected that both were witnesses to this incident and were present at the dining room nurse's station. Both stated that they witnessed R14 hitting R15 in the back and side of the head with a closed fist. Both stated that R14 had one arm encircling R15's neck while he was hitting R15. Both stated R14 was placed on 15 minute behavior checks following this incident. On 8-19-09 at 1:00 p.m. E2, Director of Nursing was asked to provide evidence of increased supervision and 15 minute checks being implemented for R14 following the 8-7-09 assault of R15. E2 stated that 15 minute checks were to be documented on log sheets maintained at the nurse's station. E2's search yielded no evidence of R14 ever being placed on increased supervision or 15 minute checks since the incident. E2 verified on 8-20-09 at 3:45 p.m. that such documentation did not exist. E2 stated that the 15 minute checks should have been started and could not explain why they were not.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 28 Interviews with Certified Nurse Aides (CNAs) E12 (8-19-09 at 12:35 p.m.), E4 and E5 (8-19-09 at 2:10 p.m.) indicated that they were routine care givers for R14 and that to their knowledge he was not on 15 minute checks and had not documented any such checks. All three stated they were not familiar with any history of physical aggression by R14. R14's 8-1-09 Physician Order Sheet (POS) reflects diagnoses including Schizoaffective Disorder, Dementia with Agitation, Bipolar Disorder, Chronic Anxiety, and Depression. His most recent (11-29-06) psychiatric clinical note documents Manic Depression with Psychotic Features. His most recent Minimum Data Set assesses him as having a short term memory problem with no long term memory problem. He is assessed as having impaired cognitive/decision making ability and has mental function that varies over the course of the day. He is assessed as having a mood issue related to persistent anger and behaviors including being verbally abusive and socially inappropriate. R14 is assessed as having no physically abusive behaviors. R14's Care Plan updated 8-5-09 reflects "...has history of making accusations--accuses former staff and current staff of stealing items--verbal abuse toward others--when interviews investigations begin--resident will then revamp his story and or refuse to tell staff who was involved." The plan or approach for this problem states to "follow through with any and all investigations--interviews needed." Another problem statement reflects "socially inappropriate. Resident will yell, scream, curse	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 29 at other residents during meals--activities and has become physically aggressive and disrupts others." Approaches for this problem include "redirect to quiet location, allow to vent--assess and assist, explain inappropriate behaviors and how outbursts affect others." There is nothing documented in R14's Care Plan that addressed any type of increased supervision or means to segregate R14 from R15 given the assault that occurred on 8-7-09. On 8-18, 8-19, and 8-20-09 R14 independently ambulated about the facility in his wheelchair without restriction or presence of staff observing his whereabouts, including trips to and from his room to the dining/activity areas, in and out of common areas, and resident living corridors all occupied by other residents. (A) 300.625g)3)A)B) Section 300.625 Identified Offenders 3) Every licensed facility shall provide to every prospective and current resident and resident's guardian, and to every facility employee, a written notice, prescribed by the Department, advising the resident, guardian, or employee of his or her right to ask whether any residents of the facility are identified offenders. The facility shall confirm whether identified offenders are residing in the facility. A) The notice shall also be prominently	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

(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) COMPLETION DATE
F9999	Continued From page 30 posted within every licensed facility. B) The notice shall include a statement that information regarding registered sex offenders may be obtained from the Illinois State Police website, www.isp.state.il.us, and that information regarding persons serving terms of parole or mandatory supervised release may be obtained from the Illinois Department of Corrections website, www.idoc.state.il.us. (Section 2-216 of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to provide evidence that a written notice describing the right to ask whether identified offenders reside in the facility has ever been provided to prospective and current residents, resident representatives, and employees of the facility. Findings include: E1, Administrator stated on 8/20/09 at 11:15 a.m., that to her knowledge, no written notice has ever been provided to prospective residents, current residents, resident representatives, and employees regarding the right to inquire about the facility's status regarding housing identified offenders. E1 stated at this time that a written notice prescribed by the Department was posted on a facility wall bulletin board. The written notice of Identified Offenders and the right to inquire was viewed/verified to be present in the facility on 8/19/09.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBYVILLE REHAB & HCC	**2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565**

(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) COMPLETION DATE
F9999	Continued From page 31 According to E1 at this time, there is one identified offender in the building at this time. (B)	F9999		