|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
|                          |   | IL6008536  |                     |  | 04/0              | ;<br>3/2025              |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | STATE, ZIP CODE  | 1 04/0            | 3/2023                   |
| SHELBY                   | VILLE HEALTHCARE  | & SENIOR LIVIN   | TH 3RD DA           |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE              | (X5)<br>COMPLETE<br>DATE |
| S 000                    | Initial Comments  |  | S 000               |  |                   |                          |
|                          | Complaint Investiga<br>2562428/IL188447<br>2562470/IL188635   |  |                     |  |                   |                          |
| S9999                    | Final Observations  |  | S9999               |  |                   |                          |
|                          | Statement of Licent<br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210d)2)3)<br>300.1810h)<br>300.3220f)  | sure Violations:   |                     |  |                   |                          |
|                          | a) The facility shall procedures govern facility. The written be formulated by a Committee consisti administrator, the a medical advisory conformer of nursing and other policies shall composities the facility and shall procedure. | advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed |                     |  |                   |                          |
|                          | Nursing and Person<br>a) Comprehensive<br>with the participation<br>resident's guardian   | General Requirements for nal Care Resident Care Plan. A facility, on of the resident and the or representative, as evelop and implement a  |                     |  |                   |                          |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/25/25 **Electronically Signed** 

STATE FORM 6899 SO9L11 If continuation sheet 1 of 12

TITLE

(X6) DATE

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--|---|---------------------|---|-------------------|--------------------------|
|  | 11 0000700  |                     |   | 0.470             |                          |
|  | IL6008536   | D. WING             |   | 04/0              | 3/2025                   |
| NAME OF PROVIDER OR SUPPL  |   |                     | STATE, ZIP CODE   |                   |                          |
| SHELBYVILLE HEALTHCA   | RE & SENIOR LIVINO  | /ILLE, IL 62        | ACEY DRIVE<br>565   |                   |                          |
| PREFIX (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROL<br>DEFICIENCY) | .D BE             | (X5)<br>COMPLETE<br>DATE |
| includes measure meet the resider and psychosocia resident's compallow the resider practicable level provide for discharce restrictive setting needs. The asset the active partice resident's guard applicable. (Second) The facility set and services to practicable physicable physicable physicable physicable. (Second) The facility set and services to practicable physicable physicable physicable physicable. (Second) The facility set and services to practicable physicable ph | care plan for each resident that able objectives and timetables to t's medical, nursing, and mental I needs that are identified in the ehensive assessment, which it to attain or maintain the highest of independent functioning, and arge planning to the least is based on the resident's care essment shall be developed with oation of the resident and the an or representative, as ion 3-202.2a of the Act)  all provide the necessary care attain or maintain the highest cal, mental, and psychological resident, in accordance with comprehensive resident care and properly supervised nursing all care shall be provided to each the total nursing and personal eresident.  absection (a), general nursing en, at a minimum, the following exticed on a 24-hour, exh basis:  ents and procedures shall be ordered by the physician.  observations of changes in a on, including mental and erequired and the need for evaluation and treatment shall be staff and recorded in the | S9999               |   |                   |                          |

Illinois Department of Public Health

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′  | CONSTRUCTION   |                                  | E SURVEY<br>PLETED       |
|--------------------------|---|--|--|--|----------------------------------|--------------------------|
|                          |   | IL6008536  | B. WING  |  |                                  | C<br><b>03/2025</b>      |
|                          | PROVIDER OR SUPPLIER VILLE HEALTHCARE   | & SENIOR LIVING 2116 SO  | DDRESS, CITY, ST<br>UTH 3RD DAG<br>VILLE, IL 625 | CEY DRIVE  |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| S9999                    | h) Treatment sheet recording all reside each resident's atte ordered procedures include, but are not treatment of decubit o determine a resident each eter/ostomy cand fluid intake and Section 300.3220 M  | s shall be maintained nt care procedures ordered by ending physician. Physician s that shall be recorded limited to, the prevention and itus ulcers, weight monitoring dent's weight loss or gain, re, blood pressure monitoring, doutput.   |  |  |                                  |                          |
|                          | administered as ord physician orders she director of nursing within 24 hours after issued to assure fa orders. (Section 2-  | ment and procedures shall be dered by a physician. All new hall be reviewed by the facility's or charge nurse designee er such orders have been cility compliance with such 104(b) of the Act)   |  |  |                                  |                          |
|                          | A. Based on interv facility failed to tran physician ordered vensure wound supptreatments were confacility failed to accuphysician ordered vensure would be supplied or change. The facility also fail facility changing the transcribing/implements. | level require more than one statement.  iew and record review the scribe and implement wound treatments, failed to olies were provided and impleted as ordered. The ommodate a request for wound treatments to be d to an alternative treatment. ed to notify the provider of the ed dressing orders, not nenting Wound Physician ers, and not notifying the |  |  |                                  |                          |

Illinois Department of Public Health

STATE FORM SO9L11 If continuation sheet 3 of 12

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | LE CONSTRUCTION<br>:  | (X3) DATE<br>COMP | SURVEY<br>PLETED         |
|--------------------------|---|--|---------------------|---|-------------------|--------------------------|
|                          |   |  | A. BOILDING         | ·   |                   |                          |
|                          |   | IL6008536  | B. WING             |   |                   | 3/2025                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY,       | STATE, ZIP CODE   |                   |                          |
| SHELBY                   | VILLE HEALTHCARE  | R SENIOR LIVING  | UTH 3RD DA          |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE            | (X5)<br>COMPLETE<br>DATE |
| S9999                    | Continued From pa   | age 3  | S9999               |   |                   |                          |
|                          | dressing orders for<br>residents reviewed<br>list of five residents<br>embarrassment an<br>extremity wounds r                         | ident request to change wound<br>one (R1) resident out of five<br>for wound care in a sample<br>s. R1 experienced pain,<br>id worsening of his bilateral<br>resulting in a 15-day<br>he treatment of his BLE<br>on.        | 1                   |   |                   |                          |
|                          | review the facility fa<br>the physician of a value treatment orders. In<br>prevent cross contact<br>for one (R2) reside               | rvation, interview, and record ailed to assess, monitor, notify wound and failed to obtain The facility also failed to amination during wound care not out of five residents d care in a sample list of five               |                     |   |                   |                          |
|                          | Findings include:   |  |                     |   |                   |                          |
|                          | admitted to the faci<br>medical diagnoses<br>Venous Hypertensi<br>extremity, Diabetes<br>Disease, Cellulitis of<br>Morbid Obesity, Ch | Face Sheet documents ility on 9/7/24 and lists R1's as Lymphedema, Chronic fon with ulcer of lower is Mellitus Type II, Parkinson's of Right and Left Lower Limbs, aronic Kidney Disease Stage 3 re and Chronic Congestive |                     |   |                   |                          |
|                          | documents R1 as of MDS documents R  | a Set (MDS) dated 1/16/25<br>cognitively intact. This same<br>t1 as requiring supervision with<br>g on and removing footwear.  |                     |   |                   |                          |
|                          | instructs staff to Ke<br>Follow facility polici   | rvention dated 9/19/24<br>eep skin clean and dry. 9/19/24<br>ies/protocols for the<br>nt of skin breakdown.  |                     |   |                   |                          |

Illinois Department of Public Health

STATE FORM SO9L11 If continuation sheet 4 of 12

| STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
|                          |   | II 0000500  |                     |  | 0.40              |                          |
|                          |   | IL6008536   | b. WING             |  | 04/0              | 3/2025                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STATE, ZIP CODE  |                   |                          |
| SHELBY                   | VILLE HEALTHCARE  | & SENIOR LIVIN  | TH 3RD DA           |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| S9999                    | Continued From pa   | age 4   | S9999               |  |                   |                          |
|                          | December 15-31, 2 February 1-20, 202 to cleanse R1's bila with soap and wate (Brand name dress drainage) with silve (Brand name comp twice per week and name compression then change to wee dressing is intact.  R1's Physician Ord | er Sheet (POS) dated 2024, January 1-31, 2025, and 25, document physician orders ateral lower extremities (BLE) er, apply zinc to peri wound, sing used to absorb wound er to open wounds, cover with oression bandage system) It as needed. Once (Brand a bandage system) is tolerated, ekly if drainage slows and |                     |  |                   |                          |
|                          | cleanse R1's BLE v<br>(Brand name petro<br>soaked gauze to op<br>semi-rigid compres<br>peri wound then wr   | cuments a physician order to with soap and water, apply leum impregnated gauze) ben areas, (Brand name sion bandage), zinc oxide to ap with dry gauze from mid h compression gauze twice per ed.  |                     |  |                   |                          |
|                          | 1/9/25, 1/23/25 doc<br>cleanse R1's BLE,<br>wound, apply (Bran<br>absorb wound drain<br>or four-layer compr<br>what is available tw   | sment and Plan dated 1/2/25, cuments a physician order to apply Zinc oxide to perind name dressing used to nage) Silver followed by two-ression wraps depending on vice per week or sooner if crated and as needed.   |                     |  |                   |                          |
|                          | document a physic<br>apply Zinc Oxide to<br>name petroleum im<br>open areas, cover  | sment and Plan dated 1/30/25 ian order to cleanse R1's BLE, peri wounds, apply (Brand apregnated gauze) cut to fit to with absorbent gauze, two- or ssion wraps depending on  |                     |  |                   |                          |

Illinois Department of Public Health

what is available three times per week or sooner

STATE FORM 6899 SO9L11 If continuation sheet 5 of 12

|                          | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                          | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|--------------------------|---|-------------------|--------------------------|
|                          |  |  |                          |   |                   |                          |
|                          |  | IL6008536  | b. WING                  |   | 04/0              | 3/2025                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                          | STATE, ZIP CODE   |                   |                          |
| SHELBY                   | VILLE HEALTHCARE   | & SENIOR LIVIN   | TH 3RD D/<br>ILLE, IL 62 | ACEY DRIVE<br>565   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE             | (X5)<br>COMPLETE<br>DATE |
| S9999                    | Continued From pa  | nge 5  | S9999                    |   |                   |                          |
|                          | if dressings are sat same plan docume and Left Dorsal ope Calcium Alginate, owrap daily and as not same plan docume cleanse R1's BLE, wounds, apply (Braimpregnated gauze with absorbent gaucompression wraps available three time dressings are satur same plan docume dressing orders the name semi-rigid coavailable, Calcium and country and count | urated and as needed. This ents R1's newly acquired Right en areas to cleanse, apply cover with absorbent pad, and   |                          |   |                   |                          |
|                          | documents a physi and bilateral dorsal wounds, apply absorbed gauze and then corper week and as not recommend the second  | sment and Plan dated 3/13/25 cian order to cleanse R1's BLE feet, apply Zinc Oxide to periorbent gauze, wrap with dry mpression gauze three times eeded.  on Assessment dated 3/14/25 off Lower Extremity (LLE) ymphedema wounds ntimeters (cm) long by the ce of R1's LLE by 0.1 cm deep heavy serosanguinous nful to R1. This same nents R1's Right Lower ellulitis/Venous Lymphedema 20.0 centimeters (cm) long by the center of R1's RLE by 0.2 cm |                          |   |                   |                          |

Illinois Department of Public Health

STATE FORM SO9L11 If continuation sheet 6 of 12

| ILEGOBSSAS  R. WING  |         | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLII<br>IDENTIFICATION NU   |   | , ,     | E CONSTRUCTION                                  |                                | SURVEY<br>PLETED |
|--|---------|---|--|---|---------|---|--------------------------------|------------------|
| NAME OF PROVIDER OR SUPPLIER  SHELBYVILLE HEALTHCARE & SENIOR LIVIN    ONLY   D  |         |   |  |   |         |   |                                | -                |
| SHELBYUILLE HEALTHCARE & SENIOR LIVIN    (X4) ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   I. (E2585)   FROVIDER'S PLAN OF CORRECTION SHOULD BE COMPILETE TAG   PREFIX   TA |         |   | IL6008536  |   | B. WING |   | 04/0                           | 03/2025          |
| Maj ID   SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY PLUI, REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   CROSS-REFERENCY   CROSS-REFERENCY   CROSS-REFERENCY   OWNER OF A PROPRIATE   OWNER O | NAME OF | PROVIDER OR SUPPLIER  |  |   |         |   |                                |                  |
| EREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 6  deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment lists R1's Right Dorsal Foot open lesion measures 8.0 cm long by 6.0 cm wide by 0.1 cm deep as macerated with moderate serosanguinous drainage that is painful to R1. This same assessment lists R1's Right Dorsal Foot open lesion measures 8.0 cm long by 6.0 cm wide by 0.1 cm deep as macerated with moderate serosanguinous drainage and R1's Left Dorsal Foot open lesion measures 8.0 cm long by 8.0 cm wide by 0.1 cm deep as macerated with minimal serosanguinous drainage and R1's Left Dorsal Foot open lesion measures 8.0 cm long by 8.0 cm wide by 0.1 cm deep as macerated with minimal serosanguinous drainage.  R1's Final Culture and Sensitivity report dated 2/9/25 documents R1's Right Leg culture showed Proteus Mirabilis, Providencia Stuartii, Stenotrophomonas Maltophilia and Diptheroids.  The undated facility Sign Out/Acceptance of Responsibility for Leave of Absence form documents R1 signed himself out on 3/16/25 at 9:30 PM. This same form documents R1's destination was to the hospital.  R1's Nurse Progress Note dated 3/16/25 at 9:54 PM documents R1's isigned himself out at 9:30 PM to go to the emergency room for bilateral lower extremity (BLE) pain. This same note documents R1's Nurse Progress Note dated 3/17/25 at 1:44 AM documents the hospital called to report to the facility R1 was being admitted to the hospital for BLE wounds.  R1's Hospital Records document R1 had multiple ulcers stage 2 through 3 on both lower legs, the rest of the affected area on both lower legs had Moisture Associated Skin Dermatitis (MASD). This same report documents R1's dressings were saturated and R1's bilateral lower legs were   | SHELBY  | VILLE HEALTHCARE  | & SENIOR LIVIN   |   |         |   |                                |                  |
| deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment lists R1's Right Dorsal Foot open lesion measures 6.0 cm long by 6.0 cm wide by 0.1 cm deep as macerated with moderate serosanguinous drainage and R1's Left Dorsal Foot open lesion measures 8.0 cm long by 8.0 cm wide by 0.1 cm deep as macerated with minimal serosanguinous drainage.  R1's Final Culture and Sensitivity report dated 2/9/25 documents R1's Right Leg culture showed Proteus Mirabilis, Providencia Stuartii, Stenotrophomonas Maltophilia and Diptheroids.  The undated facility Sign Out/Acceptance of Responsibility for Leave of Absence form documents R1 signed himself out on 3/16/25 at 9:30 PM. This same form documents R1's destination was to the hospital.  R1's Nurse Progress Note dated 3/16/25 at 9:54 PM documents R1 signed himself out at 9:30 PM to go to the emergency room for bilateral lower extremity (BLE) pain. This same note documents R1 stated he can't stand the pain anymore. R1's Nurse Progress Note dated 3/17/25 at 1:44 AM documents the hospital called to report to the facility R1 was being admitted to the hospital for BLE wounds.  R1's Hospital Records document R1 had multiple ulcers stage 2 through 3 on both lower legs, the rest of the affected area on both lower legs, the rest of the affected area on both lower legs, the rest of the affected area on both lower legs, the rest of the affected area on both lower legs had Moisture Associated Skin Dermatitis (MASD). This same report documents R1's dressings were saturated and R1's bilateral lower legs were   | PRÉFIX  | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY  | FULL  | PREFIX  | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | ON SHOULD BE<br>HE APPROPRIATE | COMPLETE         |
| weeping. R1's Hospital Record dated 3/16/25 documents R1 as wearing garbage bags around  | S9999   | deep as macerated drainage that is parassessment lists R lesion measures 6. 0.1 cm deep as maserosanguinous draftoot open lesion memore wide by 0.1 cm minimal serosanguinous draft's Final Culture 2/9/25 documents Proteus Mirabilis, F Stenotrophomonas The undated facility Responsibility for L documents R1 sign 9:30 PM. This same destination was to R1's Nurse Progres PM documents R1 to go to the emerge extremity (BLE) parastated he can't R1's Nurse Progres AM documents the facility R1 was bein BLE wounds.  R1's Hospital Recouncers stage 2 throrest of the affected Moisture Associate This same report disaturated and R1's weeping. R1's Hospital Recouncers stage 2 throrest of the affected Moisture Associate This same report disaturated and R1's weeping. R1's Hospital R1's H1's H1's H1's H1's H1's H1's H1's H | d with heavy serosan inful to R1. This same at same and R1's Right Dorsal Food on the control of the same and R1's Left and services and Sensitivity report R1's Right Leg culture and Sensitivity report R1's Sign Out/Acceptance of Absence formed himself out on 3/ne form documents F the hospital.  SS Note dated 3/16/2 signed himself out and sensitivity report and sensitivity report R1 has some and sensitivity report R1 has a sensitivity | ne at open wide by ate a Dorsal g by 8.0 with at dated the showed theroids.  The control of the | S9999   |   |                                |                  |

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STATE FORM 6899 SO9L11 If continuation sheet 7 of 12

PRINTED: 04/29/2025 FORM APPROVED

| IIIInois D               | <u>epartment of Public</u>  | Health   |                              |  |                   |                          |
|--------------------------|---|--|------------------------------|--|-------------------|--------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |   | IL6008536  | B. WING                      |  | 04/0              | 3/2025                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DDESS CITY S                 | STATE, ZIP CODE  |                   |                          |
| NAME OF I                | NOVIDEN ON OUT FIELD  |  | TH 3RD DA                    |  |                   |                          |
| SHELBY                   | VILLE HEALTHCARE  | & SENIOR LIVIN' SHELBYV  | ILLE, IL 62                  | 565  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T | .D BE             | (X5)<br>COMPLETE<br>DATE |
| S9999                    | Continued From pa   | ge 7   | S9999                        |  |                   |                          |
|                          | in about two inches legs. This same re extremities show not the billion of the weeping consistent multiple non-healing macerated tissue to same record docum saturated through a bags over his wound appropriate wound Cellulitis and nonheal Lymphedema. (R1 are erythematous a scattered shallow for Most of the wound is a wound on the Fismall amount of serosang Scattered areas of Circumference of the (cm). Circumference of the control of the work. Circumference of the control of the work. V10 stated R1 to give work. V10 stated R1 would occasionate facility did not he v10 stated R1 had hospital that night (the treatment of his | of yellow serous fluid from his cord documents R1's o cyanosis, claudication with extremity and pedal, extensive with his Lymphedema history, go venous stasis wounds, to the Left foot and ankle. This ments "(R1's) dressings are and he is dressed with plastic dod dressings. R1) is not getting management for not only his realing wounds but also his staling wounds but also his staling wounds. Multiple call-thickness skin loss noted. Deeds are red and moist. There Right Lower Leg that has a pugh noted. There is a large guinous drainage present. |                              |  |                   |                          |

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On 4/3/25 at 9:45 AM R1 stated the facility did not

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Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING:   |  |                     | (X3) DATE SURVEY<br>COMPLETED  |                                |                          |
|--|--|--|--|---------------------|--|--------------------------------|--------------------------|
|  |  | IL6008536  |  | B. WING             |  |                                | C<br><b>03/2025</b>      |
| NAME OF  | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS CITY S        | TATE, ZIP CODE   |                                |                          |
|  |  |  |  | JTH 3RD DA          |  |                                |                          |
| SHELBY   | VILLE HEALTHCARE   | & SENIOR LIVIN   |  | /ILLE, IL 625       |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM  | / FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| S9999  | follow the physician changes to his BLE V11 (Wound Physic and asked for a diff was told the facility contact V11. R1 st garbage bags on hidrainage. R1 state gauze to wrap his legauze to tie the gar that they would stay On 4/3/25 at 10:20 the facility did not n different treatments being completed as having the correct of facility was using gadrainage. V11 state and would sometim stated the facility shad the dressings would deterioration of R1' garbage bags should contain wound drain harm to R1 by keep wounds and exposimaceration due to some contain would to some contain wound drain harm to R1 by keep wounds and exposimaceration due to some contain would to some contain would that the R1 by keep wounds and exposimaceration due to some contain would that the R1 by keep wounds and exposimaceration due to some contain would that the R1 by keep wounds and exposimaceration due to some contain would that the R1 by keep wounds and exposimaceration due to some contain would that the R1 by keep wounds and exposimaceration due to some contain would some contain would that they would sate that they would sate the | orders for his dress. R1 stated he had bian Assistant/PA) to be refused he was told to was atted he was told to was lower legs to catched the staff would use and then use the bage bags onto his yup.  AM V11 (Wound PA otify her of R1's required her dressing orders ordered, the facility wound supplies or the arbage bags to contained R1 was alert and les refused to prevent and her refused to prevent and her preventionist/IP) significant wound drain AM V14 (Wound in Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to unnessitting in wound drain and Preventionist/IP) significant was refused to would have been used to the preventionist/IP) significant was refused to would have been used to would have been | asked for be called ng and y to wear in the erolled same legs so | \$9999              |  |                                |                          |
|  | his dressing orders agree to. V14 state order was changed order in the comput corporation that R1 were too costly and stated she did not r   | see R1 weekly and according to what Fed many time the dre but V14 did not chater due to being told 's specific types of could not be ordere each out to V11 (Wongs were not ordere   | R1 would<br>essing<br>inge the<br>by the<br>lressings<br>ed. V14<br>bund PA)                         |                     |  |                                |                          |

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLI<br>IDENTIFICATION NU  |  | ` ′                       | E CONSTRUCTION   | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|--|--|--|---------------------------|--|-------------------|--------------------------|
|                          |  |  |  | 7. BOILDING.              |  |                   | c                        |
|                          |  | IL6008536  |  | B. WING                   |  |                   | 03/2025                  |
| NAME OF F                | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE  |                   |                          |
| SHELBY                   | VILLE HEALTHCARE   | & SENIOR LIVIN   |  | TH 3RD DA<br>ILLE, IL 625 | ACEY DRIVE<br>565  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM   | / FULL   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE       | (X5)<br>COMPLETE<br>DATE |
| \$9999                   | R1 had been gettin stated R1's wounds in the facility due to put on, the staff not more frequently due not re-approaching R1 was refusing his B. R2's undated Fadiagnoses as Morb Obstructive Pulmor Failure, Peripheral Atrial Fibrillation, C Acute Nephritic Syr Cellulitis and Body 70.  R2's care plan interdocuments staff and location, size, and the Report abnormalities symptoms of infect Physician.  R2's Physician Ord and April 2025 does order for R2's open R2's Nurse Progres documents R2 has area.  On 4/2/25 at 10:30 sores on her Right Lymphedema. R2 Left Elbow area that | g the wrong dressing a did deteriorate durion the wrong dressing the changing R1's dresse to cost of the support of the support of the did refuse the dressing changes. The cost of the support of the did refuse the dressing changes of the support of the dressing changes. The cost of the support of the dressing changes of the dressing changes of the dressing changes. The cost of the dressing changes of the dressing dressing the dressing dressing the dressing dressing dressing the dressing dressi | ng his stay is being is sings slies and ito see why its medical b), Heart raroxysmal rtension, na, reater than it of the staff on her differs on her differs on her differs to her differs on her differs to her differs on her differs | S9999                     |  |                   |                          |
|                          | On 4/2/25 at 10:35   | AM R2 was laying ir  | n her bed  |                           |  |                   |                          |

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| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | , ,                      | LE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|--|---|--------------------------|---|-------------------|--------------------------|
|                          |  | и сесето  |                          | · · · · · · · · · · · · · · · · · · ·   |                   |                          |
|                          |  | IL6008536   | b. WING                  |   | 04/0              | 3/2025                   |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                          | STATE, ZIP CODE   |                   |                          |
| SHELBYV                  | ILLE HEALTHCARE  | & SENIOR LIVIN  | IH 3RD DA<br>ILLE, IL 62 | ACEY DRIVE<br>565   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
|                          | Left Elbow had two areas and one quar clear/yellow fluid or Elbow wounds did in On 4/2/25 at 1:15 P (Wound Nurse/LPN change to her Right wounds. V10 clear antibiotic ointment av V10 turned away frogauze, then turned Calcium Alginate robelow R2's leg. R2 dropped directly on that was soiled with R2's open wounds. contaminated Calciagain on the wound dressing change.  On 4/2/25 at 2:00 P Nurse (LPN) stated open draining wour Alginate rope sitting towel and continued rope back on R2's of should have gotten stated cross contaminated cross conta | sed, above the covers. R2's nickel sized intact blistered ter sized open area draining to R2's sheets. R2's Left not have any dressing in place.  M V10 (LPN) and V14  I/IP) completed R2's dressing to Lower Extremity (RLE) open used R2's RLE, applied and Calcium Alginate rope. Om R2 to get the absorbent back and saw that R2's use had dropped onto the towel so Calcium Alginate rope to the section of R2's towel used blood and serous fluid from V10 picked up the um Alginate rope and placed it and continued to finish the management of the wound drainage on the day to put that contaminated open wound. V10 stated she a new piece of rope. V10 minating an open wound could | S9999                    | DEI ROLLNOT)  |                   |                          |

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|                          | NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '                      | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|----------------------------|--|-------------------|--------------------------|
|                          |  | IL6008536  | B. WING                    |  | 04/0              | 3/2025                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S             | STATE, ZIP CODE  | •                 |                          |
| SHELBY                   | VILLE HEALTHCARE   | & SENIOR LIVIN   | TH 3RD DA<br>/ILLE, IL 625 | ACEY DRIVE<br>565  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| \$9999                   | training next week of physician orders, tir areas and other are The facility policy tit Monitoring revised in notification of a skin abnormality, the nut the findings in the niskin evaluation. The following procedulation treatment or treatment, location often treatment is to cleansed and a stop.  The facility policy tit. | on wound care, following mely reporting of any new skin eas of concern.  tled Skin Conditioning 3/16/23 documents upon lesion wound, or other sin rese will assess and document nurses' notes and complete a ne nurse will then implement dure: notify the physician, der which includes type of of area, frequency of how to be performed, how area is p date if needed.  tled Dressing Change revised is staff should follow the | S9999                      |  |                   |                          |

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