STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

(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 Complaint Investigation 2544225/IL192266	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

(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	S9999		

care needs of the resident.
d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

THESE REQUIREMENTS WERE NOT MET EVIDENCED BY:

Based on interview and record review the facility failed to properly transfer and use appropriate assistive devices for transfers for 1 of 3 (R2) resident investigated for falls. This failure resulted in R2 sustaining a left knee periprosthetic fracture of the tibial component.

Findings include:

R2's EMR (Electronic Medical Record) undated documents that the resident was readmitted to the facility on 7/22/24.

R2's EMR dated 2/9/22 documents a diagnosis of other abnormalities of gait and mobility.

R2's EMR dated 11/5/24 documents a diagnosis of difficulty in walking, not elsewhere classified.

R2's EMR dated 8/14/24 documents a diagnosis of unspecified fracture of left fibula, subsequent encounter for closed fracture with routine healing.

R2's MDS (Minimum Data Set) dated 7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

(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	S9999		

documents a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS documents that the resident was independent for roll left and right. The MDS documents that the resident required substantial/maximal assistance for sit to lying. The MDS documents that the resident required partial/moderate assistance for lying to sitting on side of bed. The MDS documents that the resident was dependent for sit to stand, chair/bed to chair transfer, and toilet transfer.

R2's Care Plan dated 4/30/25 documents "(R2) is at risk for falls. She had a L knee replacement and is unstable ambulating and transferring herself."

R2's Care Plan dated 4/30 /25 documents "The resident has had an actual fall with serious injury."

R2's Nursing Note dated 8/3/24 at 1:15 PM documents "cna (Certified Nursing Assistant) came to this nurse to let this nurse know that resident was lowered to the ground. CNA stated resident stated that her left leg gave out and then she was lowered her to the ground. States her left knee hurts. ROM (Range of Motion) WNL (Within Normal Limits). Transferred back to wheelchair. V/S (Vital Signs)-97.2-102-22-102/64-spo2 (oxygen saturation)-97%. On call NP (Nurse Practitioner)-for (V6) notified. No number to contact for her husband. Will monitor. Tylenol given for pain."

R2's Nursing Note dated 8/14/24 at 5:30 AM documents "X-ray results of tib/fib back- results showed fracture involving distal fibula. Management notified. X ray results were also taken on 8-4 of femur and tib/fib, results were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

(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	S9999		

negative on 8-4."

R2's NP Progress Note dated 10/8/24 documents Patient is being seen today for a skilled nursing home visit. She was recently admitted to the facility following hospitalization for UTI, debility and septic joint. She underwent arthrocentesis with orthopedic surgery and IV antibiotics during her hospital stay. She then fell in the facility and now has a left knee periprosthetic fracture of the tibial component. She is A&O x 3 and can verbalize her needs. She was seen today in-her room while sitting in her wheelchair. She has been released from her immobilizer and is WBAT to her LLE. Although, she now reports she reinjured her right knee by twisting while in the wheelchair. She states she doesn't have any pain but is unable to stand on it and now it is red again and swollen. She is utilizing the wheelchair for ambulation. Staff has no acute concerns at this time.

On 5/20/25 at 9:15 AM, V4, PTA (Physical Therapy Assistant) stated that (R2) started off as (Mechanical) lift for transfers and then transitioned to a sit-to-stand for transfer when she got here in July of 2024.

On 5/20/25 at 10:48 AM, V5, CNA stated that she was helping (R2) to the bathroom on 8/3/24. She stated that (R2) was a one assist with a gait belt. She stated that she was assisting (R2) to the bathroom. She stated that about the time they made to the doorway of the bathroom, that (R2's) leg gave out and was she assisted to the floor. She stated that they used a (Mechanical) lift to get her up off the floor.

On 5/20/25 at 10:50 AM, V4, PTA stated that on the day of (R2's) fall, she was supposed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

(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 transferred using a sit-to-stand device. On 5/20/25 at 12:32 PM, V4, PTA stated that the CNA transferring (R2) improperly lead to her having a fracture leg. She stated that the therapy was working with contact guard assist with (R2) but she was not released yet. Facility's policy undated documents "It is policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. 1. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 2. The resident's mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. (A)	S9999		