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	IL6008544	A. BUILDING: ______ B. WING ______	05/02/2025

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SHELBYVILLE MANOR	**1111 WEST NORTH 12TH STREET SHELBYVILLE, IL 62565**

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S 000	Initial Comments Annual Licensure and Certification Investigation of Facility Reported Incident of 03-21-2025/IL190891	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999		

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resident to meet the total nursing and personal 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.

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)

These Regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to prevent an incident of staff to resident physical and verbal abuse and failed to provide adequate supervision to prevent a resident-to-resident incident of physical abuse. This failure affects two residents (R76 and R62) out of four reviewed for abuse on the sample list of 35. This failure resulted in R62 suffering a high level of pain and a bump on the head and R76 being belittled and humiliated in front of residents and guests.

Findings include:

1. The facility's Initial Incident Report dated 3/21/25 documents an allegation reported from a family member (V23) that a Certified Nursing

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Assistant (V22) had used profanity towards a resident (R76) and then had put his hands on the shoulders of R76 to restrict and confine R76 to stay seated in the wheelchair.

On 4/29/25 at 10:26 AM, R76, having severe cognitive impairment and Dementia, stated he had no recollection of the incident involving the allegations against V22.

On 5/1/25 at 11:01 AM, V1, Administrator, confirmed there was an allegation against V22 reported by the family member of R2 alleging that V23 had used profanity and pushed R76 into his wheelchair. V1 further confirmed V22 had been terminated for his comments (profanity). V1 stated she had spoken with V22 who told her he did place his hands on R76's shoulders to guide him from getting up from the wheelchair but that V22 told her he did not put any pressure on R76's shoulders.

On 5/1/25 at 1:50 PM, V23, Family Member of R2, stated R2 was admitted to the facility on 3/21/25. V23 stated she had been at the facility with R2 less than one hour when she noticed R76 seated by the entrance door for the facility's Dementia unit. V23 stated R47 was standing next to R76 and R47 had his hand on R76's wheelchair armrest. V23 stated R76 leaned forward like he was going to try to see if the door would open, then V23 witnessed V22, Certified Nursing Assistant, come up behind R76's wheelchair and violently, aggressively, and quickly jerk R76's wheelchair backwards. V23 stated at that time, V22 said to R76, "Where the f**k (expletive) do you think you're going?" V23 stated that R76 never did try to stand up, just leaned forward as if to try to open the door. V23 stated she was surprised that when V22 jerked

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the wheelchair, that R76 did not fall out, and was surprised that R47 did not get knocked to the floor. V23 stated she had worked as a Certified Nursing Assistant off and on for about 30 years and had never witnessed anything like what V22 did.

R2's Face Sheet dated 5/1/25 confirmed R2 was admitted to the facility 3/21/25.

Through the survey period 4/29/25 through 5/2/25, V22 was not available for a requested interview.

V22's Employee Disciplinary Action form dated 3/21/25 documents V22 was dismissed/ terminated from employment due to violating facility policy by being discourteous, rude, and harassing a customer.

V22's Employee Disciplinary Action dated 1/21/25 documents V22 received a written warning for using profanity while working in the hallway in the presence of residents, as reported by a (unidentified) family member.

V22's Employee disciplinary Action dated 10/17/24 documents V22 received a written warning for, as reported by a (unidentified) family member, being in the dementia unit office using his cell phone while leaving residents unsupervised, and this family member found his beloved resident to be incontinent of a large amount of urine and having soiled clothing.

The facility's Abuse Prohibition and Reporting policy dated 11/28/19 documents the facility actively prohibits resident abuse including corporal punishment and protects residents from any kind of abuse such as verbal, physical, and

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corporal punishment. This policy defines verbal abuse as oral disparaging and derogatory remarks to a resident or their families within their hearing. This policy defines physical abuse as any infliction of injury on a resident by any means other than accidental, including attempting to control behavior by corporal punishment.

2. Throughout the survey period 4/29/25 through 5/2/25, R76 was observed being in a one-to-one supervision from facility staff.

On 4/29/25 at 10:30 AM, V5, Certified Nursing Assistant, stated the reason why she was sitting in a one-to-one duty with R76 was because R76 had hit another resident (R62) with a plastic bubble wand. At this same date and time R76 stated he had no recollection of this incident.

On 5/1/25 at 11:01 AM, V1, Administrator, confirmed there had been an incident when R76 hit R62 with a plastic bubble wand.

The facility's Initial Incident Report dated 4/3/25 documents an allegation made by a facility Certified Nursing Assistant (V26) that R76 had entered the room of R62, both V26 and R62 told R76 to leave the room but R76 did not comply with the request and picked up an object, later determined to be a plastic bubble wand, and began to hit R62 in the head and face.

On 5/1/25 at 3:40 PM, R62 stated she had no recollection of the incident.

On 5/1/25 at 3:52 PM, V26, Certified Nursing Assistant, stated he was in a resident's room directly across the hall from R62's room when he saw R76 go into R62's room. V26 stated he had called out to R76 to not go into that room, but he

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could not leave the resident he was providing care to. V26 stated R76 did not comply with his request to not go into the room. V26 stated that R62 likewise told R76 to get out of her room, but again, R76 did not comply. V26 stated R76 then picked an object up from R62's dresser and began to hit R62 on the head and face with it, causing R62 to fall to the floor. V26 stated when he was able to get to R76, the object was a plastic bubble wand. V26 stated he asked a co-worker to report this incident to the nurse (V28) while he monitored R76.

R76's Nurses Note dated 4/3/25 at 1:21 AM, documented by V28, Licensed Practical Nurse, documents R76 struck another resident (R62) in the head with a bubble wand causing injury to R62. R76's Nurses Notes document multiple weekly incidents of R76 being verbally and physically aggressive towards staff.

R62's Nurses Note dated 4/3/25 at 12:15 AM, documented by V28, Licensed Practical Nurse, documents R62 was noted to have a bump on the side of her head measuring 3 centimeters long by 2 centimeters wide by 3 centimeters high and slight purple bruising on her left ear. This note further documents R62 was complaining of dizziness and a headache, with a pain rating of eight out of ten.

(B)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210c)
300.1210d)6)

Section 300.610 Resident Care Policies

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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 care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on record review and interview, the facility failed to provide a cognitive impaired resident, who required substantial to maximum staff assistance, with a safe transfer and toileting. This failure resulted in R57 sustaining two fractures on 3/12/25, that required emergency medical attention and surgical repair. The facility also failed to initiate targeted post-fall interventions to address the root cause of self-toileting. These failures affected one of three residents (R57) reviewed for falls on the sample list of 35.

Findings include:

R57's Minimum Data Set dated 3/12/25 documents R57's Brief Interview for Mental Status score was 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS inaccurately (according to V20, MDS/Care Plan Coordinator and V27, Nurse Practitioner below interviews) documents R57 had no falls prior to admission to the facility.

R57's Face Sheet documents his admission date as 3/6/25. The same Face Sheet includes the following diagnoses: Dementia in Other Diseases, Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Other Lack of Coordination, Difficulty in Walking, Not Elsewhere Classified, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites.

R57's Admission Assessment dated 3/6/25, documents: R57's "Fall Risk Score" of 16 (High

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Risk), using the following fall risk scale: "Scoring: 0-5 Total Points equals Low Fall Risk, 6-13 Total Points equals Moderate Fall Risk, greater that 13 Total Points equals High Fall Risk."

R57's "Physical Therapy (PT) Evaluation and Plan of Treatment" dated 3/6/25 documents R57's diagnoses as follows: Urinary Tract Infection, Site Not Specified, Difficulty in Walking, Not Elsewhere Classified, and Muscle Wasting and Atrophy, not elsewhere classified, Multiple Sites. The same PT evaluation document: R57 required substantial/maximal staff assistance with transfers.

R57's "Resident Care Information" Certified Nursing Assistants Task sheet dated 3/10/25 directs staff to transfer R57 with one assist, front wheeled walker and to use a gait belt.

R57's "Safety - Fall Event" report documents R57 fell on 03/12/2025 at 1:00 pm. The same report documents: "Staff report resident (R57) noted to be in (on the) floor. Upon arrival, resident noted to be laying on back in (sic) floor, in front of (the) doorway, with (his) head facing (the) doorway and (his) feet facing (the) window. W/C (wheelchair) noted to be parked at foot of bed, facing window. No O2 (oxygen) on. Resident states 'I was trying to go to the bathroom, and I tripped over my heel'. Environment free of clutter. Room well lit. Call light not activated. Non-skid shoes on. Resident c/o (complained of) pain 10/10 (on a scale of 0-10, 10 being the worst pain level on the scale) to left shoulder and left hip, unable to complete ROM (range of motion). Resident states he did not hit his head, neuros (neurological assessment) WNL (within normal limits). VS (vital signs) Temperature:97.6, Pulse:70, Respirations:18, Blood Pressure: 136/72, Oxygen

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Saturation (blood saturation level): 90% RA (room air), Oxygen placed on resident, at 2 L/min (two liters per minute) (via) NC (nasal cannula). Resident made comfortable on floor. MD (unidentified physician) notified, N.O. (new order). Send to ER (hospital emergency room) for eval (evaluation) and tx (treatment)."

The same "Safety-Fall Event" documents: "On 3/12/2025 at 3:36 pm, received call from (local hospital) ER (emergency room), ER (unidentified) nurse states resident has a fractured left shoulder and a fractured left hip and will be transferred to a higher level of care hospital. ER nurse does not know which hospital resident is being sent to at this time but will contact facility as soon as information becomes available. DON/Administrator (V2, Director of Nursing/V1, Administrator) notified."

R57's "Regional Level 1 Trauma Center, Acute Care Surgery Service: Emergency Surgery. Trauma, Surgical Critical Care Hospital (hospital, long distance from the facility)" record, documents the following: "HOSPITAL COURSE: (R57's name and age) who presented on 3/12/2025 at 6:30 PM, as a transfer from (hospital, shorter distance from the facility) after he suffered a mechanical fall at his nursing home. He was found to have left humerus fracture and left femoral neck fracture. A (name brand indwelling urinary catheter) was inserted at the previous hospital prior to transfer. Orthopedic Surgery was consulted and planned for operative intervention the next day."

The same hospital record documents: "He (R57) underwent in-situ fixation (surgical repair) of left femoral neck fracture on 3/13/25 with (Orthopedic Surgeon). His humeral fracture is being managed

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S9999	Continued From page 10 non-operatively with a sling. He is weight-bearing as tolerated to the left lower extremity, and non-weight bearing to the left upper extremity." On 4/30/25 at 10:40 am V2, DON stated "(R57) was not to ambulate unless he was working with therapy." V2, DON also stated V7, Certified Nursing Assistant (CNA) was the staff member that found R57 on the floor post fall. On 4/30/25 at 10:55 am V7, CNA walked down to the empty room on 400-hall that R57 resided in when he fell 3/12/25. V7, CNA confirmed V2, DON's observation and stated "(R57's) head was close to the open door of his room. His feet were directed towards the window where his wheelchair was at. I did not pay attention to if his wheelchair was locked or unlocked. I was focused on the patient (R57). (R57) said he was going to the bathroom when he fell. The bathroom is pretty far from here, where he laid. (approximately 8 feet away). I don't know if he was incontinent at the time of his fall. He was not wet on the outside of his clothes. The last time I saw him, he was in the small dining room eating about a half hour before he fell. I did not take him to the bathroom before lunch. He always took himself. He was independent (per admission and therapy notes above R57 required substantial to maximum staff assistance with transfer) when I worked. He never asked for help. For the most part he was alert and oriented (diagnoses documented above as Dementia). I don't know if he had a history of falls, he had not been here very long (admitted six days prior to the fall)." On 4/30/25 at 12:40 pm V2, Director of Nursing stated "(R57) was moved to the room closer to the nursing station when he returned from the hospital post fall (3/12/25). That was the	S9999		

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intervention to increase supervision. It makes sense that we should have identified why he was trying to self-transfer. He should have had assistance. He was going into bathroom. His intervention should have included increased toileting, in addition to increasing (R57's) supervision."

On 5/1/25 at 3:30 pm V27, Nurse Practitioner stated "I have known (R57) long before he was a resident in the facility. He had numerous falls when he was at home. He had a very unstable gait. He should have had assistance with ambulation, transfers and toileting. He was somewhat impulsive. I was not surprised when I heard he had the fall with the fractures. I did not realize staff were not providing him the assistance he needed. He was admitted to the facility and was receiving PT (Physical Therapy) for strengthening. Yes, he should have been toileted by staff. He was trying to toilet himself, from what I understand, that was the root cause of his fall."

On 5/2/25 at 1:30 pm V20, Minimum Data Set (MDS)/Care Plan Coordinator, stated R57's MDS did not document that R57 had previous falls, because the facility did not have his history when he was admitted 3/6/25. "He is moderately impaired and did not remember falling prior to admission. Now we know his history. The fall here in the facility 3/12/25 with fractures, is listed (documented) on the MDS because his assessment goes until midnight on 3/12/25."

(A)