

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
NAME OF PROVIDER OR SUPPLIER PIATT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST MONTICELLO, IL 61856		
(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 Investigation of Facility Reported Incident of 4/14/25/IL191073	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6)	S9999		
	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			

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/13/25

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
NAME OF PROVIDER OR SUPPLIER PIATT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST MONTICELLO, IL 61856		
(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	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>THESE REQUIREMENTS WERE NOT MET EVIDENCED BY:</p> <p>Based on interview and record review the facility failed to prevent an injury by failing to ensure a bed was in a low position for one (R1) of three residents reviewed for falls on the sample list of three. This failure resulted in R1 sustaining a laceration to the right forearm, a hematoma, and spinal fracture which required emergency medical treatment.</p> <p>Findings include:</p> <p>The facility's Managing Falls and Fall Risk Policy with a revision date of 12/2021 documents that staff will identify and implement relevant interventions to try to minimize serious consequences of falling.</p> <p>R1's Care Plan initiated on 9/3/2019 documents that R1 was at risk for injury related to mobility</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
NAME OF PROVIDER OR SUPPLIER PIATT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST MONTICELLO, IL 61856		
(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	<p>Continued From page 2</p> <p>status. This Care Plan documents that R1 has a history of skin tears, bruises, and a history of falls. This Care Plan documents an intervention for the bed to be in the lowest, most appropriate position when resident is resting in bed.</p> <p>R1's Incident report dated 4/14/2025 documents R1 was found on the floor next to the bed at 10:40 PM by V9, Certified Nurse's Assistant. This report documents R1 had large laceration to the right forearm and a large hematoma (bruised knot) to the right forehead. R1 was sent to the Emergency room for evaluation. This report documents V6, Licensed Practical Nurse found that R1's bed was not in the low position stated in the Care Plan.</p> <p>R1's Emergency Room summary dated 4/15/2025 documents that R1 had a fall out of bed that resulted in broken bones to R1's spine and a contusion on R1's forehead. This report documents R1 required pain medication (Norco) to relieve R1's pain from the injuries.</p> <p>On 5/5/2025 at 1:37 PM, V9 stated he was doing his 10 PM resident checks and walked into R1's room and saw her on the floor and immediately went and got the nurse. V9 stated R1's bed was in the high position when he found R1 on the floor which isn't facility protocol. V9 stated that he was 6 foot tall, and the bed was at his hip level. V9 stated he went and got V6 for help.</p> <p>On 5/5/2025 at 11:37 AM, V6 stated on 4/14/25 around 10:40 PM, V9 came and told me that R1 was lying on the floor. V6 stated when she walked into the room, R1 was laying on the floor next to the bed. V6 stated that she noticed R1 had a pretty good-sized goose egg on her head from falling out of bed. The goose egg was the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
NAME OF PROVIDER OR SUPPLIER PIATT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST MONTICELLO, IL 61856		
(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	<p>Continued From page 3</p> <p>size of a fist. V6 stated she called 911 and kept R1 on the floor in the same position. V6 stated that the bed was not in the low position and that it was up higher than she thought it should be. V6 stated that R1's bed was at her waist level, and she is 5 foot 5 inches tall.</p> <p>On 5/5/25 at 2:13 PM, V2 Director of Nursing stated R1's intervention of a low bed was put into place upon admission (9/13/2019) to reduce her risk of injury if she were to fall out of bed.</p> <p>On 5/5/2025 at 2:51 PM, V10 (R1's Nurse Practitioner) stated she saw R1 in the facility after the fall with injury. V10 stated R1 had bruising to her face. V10 stated R1's injuries were a result of her fall on 4/14/25. V10 stated that if the bed was in a lower position at the time of the fall R1's injuries would not have been as bad.</p> <p>(B)</p>	S9999		