

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Shelbyville Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 West North 12th Street Shelbyville, IL 62565	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0604 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview, and Record Review the facility failed to identify full body pillows and a concave mattress as restraints, failed to assess the resident for the use of the full body pillows and concave mattress, and failed to ensure that the body pillows and concave mattress did not pose a risk of injury from falls for one (R1) of eight residents reviewed for restraints on the sample list of eight. This failure resulted in R1 who is at high risk for falls and has cognitive impairment climbing out of bed and falling on multiple occasions while the full body pillows were in place. This failure ultimately resulted in R1 climbing out of bed and falling and sustaining a left pelvic fracture. Findings Include: On 10/21/2025 at 10: 55 AM, R1 was lying in bed on top of a concave mattress. Full-length body pillows were placed on top of the concave mattress and were positioned along both sides of R1's body underneath a fitted sheet. On 10/22/25 at 10:10 AM, R1 was lying in bed on top of a concave mattress. Full-length body pillows were placed on top of the concave mattress and were positioned along both sides of R1's body underneath a fitted sheet. R1's Progress Note dated 7/20/25 documents R1 has increased restlessness and anxiety this noc (night). Res (Resident) has exited bed and ambulated into hall multiple times this noc. Bed in lowest position, call light is within reach but not activated. Floor mats in place next to bed and body pillows in place beside resident in bed. Res gait and balance unsteady, Res frequently asking questions like Where am I supposed to be? What am I supposed to do? Where are my morn (mom) and dad?. Each time resident easily redirected, toilet offered, fluids offered and accepted, then res assisted back to bed. Res denies pain or discomfort. Res has not been incontinent of B/B (bowel/bladder). PRN (as needed) Ativan administered earlier in shift and somewhat but temporarily effective. R1's Minimum Data Set assessment dated [DATE] documents R1 is cognitively impaired and has a history of falls. R1's Post Fall Interdisciplinary notes document R1 was found on the floor at the end of her bed on 8/18/25 and 9/26/25. R1's care plan documents a fall intervention for a concave mattress on 8/18/25. R1's medical record does not contain an assessment for the use of the concave mattress or full-length body pillows. R1's Post Fall Interdisciplinary Notes document on 10/10/25 at 9:35 PM, R1 was observed sitting at the foot of her bed; (on the floor) on her buttocks with legs outstretched in front of her after attempting to self-transfer. This note documents the full body pillows were in place. This note documents R1 was sent to the hospital on [DATE] after complaining of pain. This note documents R1 was found to have a Left Superior Pubic Rami Fracture (pelvic fracture). This note does not document an assessment or reassessment for the use for the concave mattress or the body pillows. On 10/21/2025 at 11:35 PM, V4 Certified Nursing Assistant (CNA) stated she takes care of R1. V4 stated the body pillows are used so R1 doesn't get out of bed. V4 stated R1 can put her legs over the body pillows if R1 is determined to get out of bed. V4 stated that R1 can ambulate with assistance and has had body pillows since V4 has been taking care of R1 since April 2025. On 10/21/2025 at 11:40 AM, V5 CNA stated she has taken care of R1 since April 2025. V5 stated R1 has always had body pillows in place while in bed and if R1 is not in bed, R1 is to be up at the nursing station for closer supervision. V5 stated, R1 transfers with one assist. V5 stated R1 requires frequent visual checks because R1 likes to get out of bed and ambulate throughout the day and night. V5 stated R1 falls frequently because she is unsteady and requires assistance with walking. V5 stated that body pillows are to be placed under the sheet to keep R1 from getting up and walking by herself. When asked about R1's care plan, V5 looked at R1's electronic health record and stated R1's care plan does not include the use of the body pillow. V5 also stated R1's record did not contain an assessment for the use of the body pillows on R1's bed. On 10/21/2025 at 11:17AM V7 Licensed Practical Nurse (LPN) stated, R1 likes to get up by herself and the body pillows that are on each side of the bed are to prevent falls. V7 stated there is no assessment for the body pillows in the chart or care plan but staff were told by the facility to keep the body pillows on while R1 was in bed. On 10/21/2025 at 12:30PM, V11 Registered Nurse stated, If (R1) is determined she will find a way out of her bed as she is a high-risk faller. On 10/21/2025 at 12:56 PM, V2 Director of Nursing stated the body pillows are used to prevent R1 from getting out of the bed. V2 stated a restraint assessment should have been completed for the use of the body pillows and reassessed after each fall. At that time, V2 looked at R1's electronic medical record and confirmed there were no restraint assessments in the medical record and no interventions on the care plan related to the use of the full-length body pillows. V2 stated that the fracture was related to the fall on 10/10/25 and the body pillows were in place on R1's bed before the fall. On 10/21/2025 at 12:45 PM V8 (R1's Hospice Nurse Practitioner) stated using the full body pillows on top of a</p>		