

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 11/16/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to update one (R1) resident care plan with fall interventions, repeatedly failed to implement fall interventions and complete thorough fall investigations for two (R1, R2) residents out of three residents reviewed for accidents in a sample list of eight residents. Findings include: 1.R1's undated Face Sheet documents medical diagnoses as Dementia, Psychotic Disturbance, Diabetes Mellitus Type II, History of Urinary Tract Infection (UTI), Vitamin B deficiency, Pain and Vitamin D deficiency. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 requires supervision with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers.R1's Fall Risk Evaluation dated 10/7/25 documents R1 as a high fall risk. R1's Nurse Progress Note dated 9/29/25 at 7:15 AM, documents R1 had an unwitnessed fall in her room just outside the bathroom. This same note documents R1 was ambulating from her bed to the bathroom, lost balance and fell to the floor R1's Care Plan intervention dated 9/29/25 following R1's fall on 9/29/25 was for R1 to use the alternate call system. R1's Nurse Progress Notes dated 10/4/25 at 8:45 AM, 10/7/25 at 3:42 PM and 10/9/25 at 9:15 PM documents R1 falling at the facility. On 11/15/25 at 12:50 PM, V5 Licensed Practical Nurse (LPN) stated R1 had Dementia and would not remember to use her call light or ask for help. V5 LPN stated R1's fall on 10/4 was witnessed 'but the staff had to help her down or she would have hit the ground'. V5 LPN stated a Certified Nurse Aide (CNA) was helping R1 when R1's legs 'went weak'. V5 LPN stated she did not remember which CNA it was. V5 LPN stated no one from management ever asked her to complete a witness statement or asked her any questions about the fall. On 11/15/25 at 2:25 PM, V4 Registered Nurse (RN) stated on 10/9/25 R1 had an unwitnessed fall in her room while attempting to walk to the bathroom. V4 stated she heard a loud noise and when she investigated, found R1 lying on the floor in her room. V4 RN stated she was not asked to complete a witness statement. V4 RN stated she was not asked any 'detailed' information about R1's fall. On 11/16/25 at 12:50 PM, unable to leave message for V20 LPN due to voicemail full. On 11/16/25 at 1:00 PM, V2 Director of Nurses (DON) stated the CNA who was involved in R1's fall on 10/4/25 was V11. V2 DON stated she found V11's name by searching through the Daily Staffing sheets for that day. V2 DON stated the facility does not document staff names in the resident's Electronic Medical Record (EMR) and does not ask staff for witness statements. V2 DON stated this should be a part of the fall investigation but the facility 'doesn't keep track of who was involved in resident's falls'. V2 DON stated there is no way to know other than re-interview the nurse who wrote the progress note or look at the daily staffing sheets. On 11/15/25 at 3:15 PM, V7 Care Plan Coordinator/Licensed Practical Nurse (LPN) stated the facility conducts a morning meeting Monday through Friday to discuss any resident changes/concerns/updates. V7 CPC stated over the weekend there is a nurse on call to handle any situations that arise. V7 CPC stated when a resident fall there should be a fall intervention to 'match' each fall. V7 CPC stated that intervention should be put into place immediately, reviewed in morning meeting and either placed on the resident care plan then or changed to a more appropriate intervention. V7 CPC stated R1 had multiple falls with interventions added into the care plan for 'most'. V7 CPC stated she could not find an intervention for R1's 9/16/25 or 10/7/25 fall. On 11/15/25 at 3:30 PM, V14 Assistant Director of Nurses (ADON)/Registered Nurse (RN) stated all fall investigations should include basic information of who the resident/staff were that were involved, how the fall happened, what time it happened, if there were injured, what were the surroundings like, what care plan interventions were put into place and any other pertinent information relating to the resident's fall. V14 ADON stated a new intervention is supposed to be entered into the resident's care plan directly after a fall. V14 ADON confirmed R1 did not have fall interventions for R1's 9/16/15 and 10/7/25 falls. V14 ADON stated the fall intervention is put into place to help reduce the risk of the resident from falling again the same way. V14 ADON stated if the interventions are not implemented then the resident could fall again and 'maybe get injured'. 2. R2's undated Face Sheet documents R2's medical diagnoses as Encephalopathy, Dementia, Anxiety, Muscle Wasting and Atrophy, Repeated Falls, Vitamin Deficiency, and difficulty in walking.R2's Minimum Data Set (MDS) dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 requires maximum assistance from staff with oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers.R2's Care Plan intervention dated both 6/4/25 and 10/1/25 documents an intervention of 'alternative call light' R2's Nurse Progress Note dated 10/13/25 at 6:24 AM documents R2 had an unwitnessed fall in</p>		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure hot water heaters housed in resident closets are sanitary for six (R1, R4, R5, R6, R7, R8) residents out of six residents reviewed for Physical Environment in a sample list of eight residents. Findings include:R1's Minimum Data Set (MDS) dated [DATE] documents R1 as moderately cognitively impaired. This same MDS documents R1 requires supervision with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers.R1's Electronic Medical Record (EMR) does not include V6 (R1's) Power of Attorney (POA) concern of R1's hot water heater in R1's closet having 'mold, lime build up and rust'. On 11/15/25 at 1:20 PM, R4 and R5's shared closet housed a ten-gallon hot water heater. This water heater had a bright green and white dry substance covering the front quarter of the water heater, approximately six inches off the closet floor underneath and approximately eight to ten inches of the pipes attached to the water heater leading to the wall. The closet floor close to the perimeter of the water heater had a brown substance appearing to be rust. The wall behind the water heater on both sides had approximately three inches of black dots, some faded and some had clear edges appearing to be black mold. On 11/16/25 from 11:15 AM-11:30 AM, V2 Director of Nurses (DON) toured rooms with hot water heaters in the closets. V2 DON stated there are five rooms with hot water heaters in their closets. V2 DON stated four of the five rooms are occupied with residents. R4 and R5's shared closet housed a water heater that showed bright green and white dry substance that appeared as lime build up, rust and black dots on the wall that appeared as black mold. R6 and R7's hot water heater located in their shared closet showed a large area of brown flaky substance on the floor that appeared as rust. R8's water heater located in the closet showed bright green and white dry substance appearing as lime build up on the floor, the water heater and the pipes attached to the water heater. On 11/15/25 at 10:10 AM, V6 (R1) family stated R1 had a hot water heater in her closet that sat directly beneath her clothes causing her clothes to be 'very warm'. V6 stated the front of R1's hot water heater is 'a lot of lime build up' and on the back wall behind the water heater is 'mold all over the wall'. V6 stated she reported this to V7 Care Plan Coordinator during R1's last care plan meeting. V6 stated the facility did not 'fix the problem'. V6 stated having a hot water heater causes R1's clothes to be very warm and having 'mold and lime buildup' would be a health risk for any resident.On 11/15/25 at 1:25 PM, R4 stated the water heater 'has been like that' since she admitted to the facility. R4 stated the water heater is on her roommate's (R5) side of the closet but R4 backs into 'that thing' every time she gets into her closet. On 11/15/25 at 1:30 PM, R5 stated her clothes hang directly over the water heater. R5 stated she had a long robe hanging up in her closet that rested on top the water heater. R5 stated she reached in for her robe. R5 stated her robe was so hot she thought it would 'catch fire'. R5 stated she reported this to the facility last week and V16 Maintenance Director told her it would get fixed. R5 stated With all of that mold, rust and lime build up I worry that we (R4, R5) will get sick. On 11/15/25 at 1:35 PM, V15 Custodian stated there are several rooms with water heaters located in the resident closets. V15 stated (R4, R5)'s water heater is in 'the worst shape'. V15 stated the facility is working on getting that one fixed first. On 11/15/25 at 1:40 PM, V16 Maintenance Director stated he has been working with 'corporate' to get the closet water heaters replaced. V16 stated he was aware of the 'mold, rust and lime build up on a few' of the closet water heaters. V16 stated resident clothes do hang over the water heaters but should not be touching them. V16 stated the water heaters will not get hot enough to be a fire hazard but the 'lime, rust and mold could make people sick'. V16 Maintenance Director stated the water heaters that could be a risk to the residents are being replaced first. On 11/16/25 at 11:10 AM, V7 CPC stated V6 (R1) Power of Attorney (POA) called V7 to inquire about a water heater in R1's room having 'mold, rust and a bunch of stuff' all over it. V7 CPC stated she reported this to V1 Administrator in the next day's morning meeting. V7 CPC stated I don't know whatever was done with that, but I reported it to (V1). That was (V1's) responsibility then, not mine. V7 CPC stated there was no progress note made about this concern. V7 CPC stated she did not remember what date V6 called her. On 11/16/25 at 2:30 PM, V1 Administrator stated the facility has 'several' hot water heaters that are located in closets in resident rooms on three different hallways. V1 stated she was 'just made aware' that three of those water heaters had 'mold, mildew and rust' on them that could cause a potential health risk to a resident. V1 Administrator stated the water heaters 'probably' don't get hot enough to cause a fire hazard but also should not have 'mold, mildew and rust' on them within the resident areas. V1 Administrator stated V16</p>		