STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	1111 West North 12th Street Shelbyville, IL 62565

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement post fall interventions for one resident (R3) of four residents reviewed for falls on the sample list of four residents. R3's fall resulted in spinal fractures and a right ankle fracture which required R3 to wear a back brace, compression wrap to the ankle and a surgical shoe for non-surgical intervention to treat severe pain. R3 sustained severe pain when interventions were not implemented.Findings include:R3's Current admission Diagnoses Sheet dated 4/28/26 upon return from the hospital post-fall 4/16/26 documents the following: Age-Related Osteoporosis with Current Pathological Fracture, Vertebra (e), Subsequent Encounter for Fracture with Routine Healing (Primary), Low Back Pain, Unspecified (Admission), Wedge Compression Fracture of Fourth Lumbar Vertebra, Subsequent Encounter for Fracture with Routine Healing, Long Term (current) use of Anticoagulants, Personal History of (healed) Osteoporosis Fracture, Chronic Atrial Fibrillation, Unspecified, Pain, Unspecified, and Essential (Primary) Hypertension.R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status score of 13 out of a possible 15, indicating no cognitive impairment.R3's Progress Note dated 04/16/2026 at 09:03 AM documents R3 fell while walking to the bathroom in R3's room. R3 normally ambulates independently with R3's walker. Neuros WNL (Neurological assessment- within normal limits). Vital signs within normal limits (WNL). R3 stated R3 did hit R3's head when R3 fell. Room is clean and free of clutter. R3 was wearing non-skid socks at the time of fall. R3 stated R3 is not sure how R3 fell that it happened too fast. R3 was complaining of very severe back pain, which is not far from R3's baseline as R3 does complain of back pain on a day-to-day basis. R3 was sent out to a local hospital and later transferred to a distant hospital to be evaluated. V21 (R3's) Family Member/Power of Attorney (POA) and V3 Medical Director/Physician were notified.R3's Progress Note dated 04/28/2026 at 10:54AM (twelve days after admission to distant hospital) documents that report was received from the nurse at the distant hospital. R3 was admitted to the hospital on [DATE] after falling at Nursing Home. R3 was noted to have a broken back-had kyphoplasty (medical procedure of the spine) done on 4/27/26 with no complications. Follow up with V29 Orthopedic Physician, needed in two weeks, transport made aware. R3 has a TLSO (Thoracolumbar Sacral Orthosis) back brace to be in place when up. R3 is a two-assist pivot transfer, incontinent of bowel and bladder, and last bowel movement was 4/27/26. Incision to back covered with sterile dressing to be in place until 4/29/26, then leave adhesive strips in place and leave incision open to air. R3 to resume, Coumadin (oral blood thinner/anticoagulant medication) today. CT (Computed Tomography specialized X-ray) of right ankle after fall also showed a displaced fracture. Boot to be worn when walking. Chest Xray showed Pneumonia, and R3 has completed R3's five-day course of antibiotic medication treatment.R3's current Physician Order Sheet (POS) documents: Surgical Incision to back: monitor incision for signs and symptoms of infection. Adhesive bandage strips in place, leave incision open to air, leave adhesive strips in place until they fall off. This should be monitored every shift. R3's same POS documents: Right ankle/foot: Walking Boot (error in documentation as noted in interview below- this should read surgical shoe with ankle wrap) on at all times during transfers/ambulation related to ankle fracture. R3 should wear TLSO (Thoraco-Lumbo-Sacral Orthosis, back) brace when (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	up.R3's same POS identified pain medication that the physician ordered on R3's readmission on [DATE] (R3's post-fall 4/16/26). The POS documents the following:1. Lidocaine adhesive patch medicated; 5 (five) percent; amt (amount): 1 (one); topical, Every 12 hours, 05:00 PM and 05:00 AM (routine).2. Gabapentin capsule; 100 mg (milligrams); amt (amount): 1 (one); orally, at bedtime 08:00 PM. (routine)3. Extra Strength Acetaminophen (acetaminophen) [OTC] (over the counter, no prescription needed) tablet; 500 mg; amt (amount): 1 (one); orally, Twice A Day - PRN (as needed).R3's same POS lists a more potent narcotic pain medication used to treat moderate to moderately severe pain, opioid controlled substance medication is documented as follows: Tramadol - Schedule IV (four) tablet; 50 mg; amt (amount): 1 (one) tablet; orally, Every 6 (six) Hours - PRN (as needed) [DX (Diagnosis): Low back pain, Unspecified-Lumbar Region].R3's corresponding Medication Administration Record (MAR) documents R3 received 17 doses of Tramadol between 5/1/26 - 5/5/26. The same MAR documents the letter P to indicate R3 had pain. The MAR does not document a pain scale measurement to quantify the level of pain being treated with the Tramadol. R3's Care Plan dated 3/20/26 (initial admission prior to fall 4/16/26) documents the following:Problem Start Date: On 03/20/2026, R3 has functional mobility related to medical status. Short Term Goal established stating that R3 will be able to ambulate, with assistance of one staff and walker during this quarter with a target date of 07/06/2026.R3's Care Plan dated 3/20/26 also documents R3 is to complete transfers using a four wheeled walker. It is documented that R1 ambulates independently in room using wheeled walker, with assistance of one when ambulating outside of room.R3's Care Plan dated 3/20/26 states R3 is at risk for falling related to recent (prior to fall, on first admission 3/20/26) Kyphoplasty (spinal procedure to heighten Osteoporotic compression fractures), weakness, pain, and Osteoporosis.This Care Plan also documents on 04/16/2026 (post-fall 4/16) R3 was educated to call before getting up.R3 is at risk for loss of voluntary range of motion to upper and lower extremities related to back pain, recent kyphoplasty, and osteoporosis. R3 will maintain voluntary range of motion of Upper/lower extremities as tolerated. Resident Care InformationPer the care plan, R3 should use a standard wheelchair, with specialty positioning- type cushion to prevent skeletal deformities, footrests, and TLSO brace should be worn when up.On 5/5/26 at 12:30 PM, R3 was partially reclined in a bedside recliner chair. R3's head was elevated approximately 45 degrees. R3 stated R3 can't put R3's brace on by R3's self. R3 stated R3's back is broken in several places. R3 came to the facility for therapy after R3 had surgery on R3's back. R3 had two breaks in R3's spine then. One is in the lower part of the neck, kind of between R3's shoulders. The other one fracture is lower. R3 stated R3 is almost [AGE] years old. R3 stated R3's bones break easily. R3 stated that when R3 fell at the foot of R3's bed, it was no one's fault but R3's own fault. Therapy had just told R3 the day before R3 fell, R3 was cleared to walk in R3's room on R3's own. R3 was going to the bathroom, when R3 lost R3's balance, and fell. R3 stated that R3 also hit R3's head and has a small fracture in R3's right ankle. R3 stated R3 is supposed to wear R3's brace anytime R3 is out of bed. R3 is not sure why the staff took the brace off. R3 stated R3 really wants R3's back to heal, so R3 can go back home. R3 was almost ready to go back home after therapy was completed. Then R3 fell and required more therapy. R3 stated it is not the facility's fault that R3 fell. R3 also reported that R3's knee is sore. R3 reported R3's right knee is bruised pretty good too. R3 reported R3 is supposed to wear a boot, they said in the hospital. R3 stated R3 doesn't know why they said boot, then put this shoe on R3. R3 stated R3 wears this shoe, but R3 really thinks R3 is supposed to have a boot. They had R3's ankle wrapped up good and R3's ankle pain seemed to be a lot less when R3 wore that. All the nurses don't put that on here at the facility per R3's report. R3 does have a bandage on R3's shin. R3 stated R3 banged that up and has a sore area. R3 pulled back the blanket covering R3's right lower leg. R3 remained seated but leaned forward to display R3's right shin bandage, right foot orthopedic shoe and R3's bare right ankle. R3 leaned forward and said Oh, oh, my back hurts so bad without my back brace on. R3 leaned back into the recliner chair, lowered R3's blanket off R3's chest and said I do not have my brace on. It is in the chair (straight back stationery). R3 stated R3 really needs R3's back brace. R3 reported having a lot (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	less pain with the back brace on. R3 stated R3 is hoping it will promote R3's spine to heal, so R3 can go home. R3 didn't know anything more about the boot. R3 reported that the back brace and that wrap with that shoe or whatever they call it makes R3 feel a lot less pain. Sometimes the pain in R3's back is excruciating without the back brace on. R3 reported feeling so much better when R3 wears them. R3 reported feeling more secure, and R3's back is a lot less painful. R3 stated R3 is not sure why, V12 Certified Nursing Assistant (CNA) took the brace off. R3 reported that V12 transferred R3 to the chair, then left R3's room so fast, R3 did not have a chance to tell V12 to put R3's brace back on. R3 stated this has happened several times by a couple of different CNAs. R3 is only supposed to have R3's back brace off when R3 is lying in bed. R3 stated there is no pressure on R3's back when R3 is in bed. R3 stated R3 has a skinned area under the bandage wrap on R3's shin. R3 also stated, this bandage does nothing for my ankle. R3 does take medication for all R3's pain. R3 stated it helps to keep R3 somewhat more comfortable. It is the brace that gives R3 the support and gives R3 the most relief from R3's pain. R3 then asked this surveyor Would you talk to the nurse, let her know I need my back brace on. Also ask her to lower this (bandage) to my ankle look at my sore and knee.On 5/5/26 at 12:40 pm, V13 Registered Nurse (RN) entered R3's room and assessed R3's right kneecap bruising. V13 RN confirmed R3's kneecap was blue and purple and measured approximately, the size of a quarter. R3 stated to V13 that R3's kneecap was tender to the touch. R3 reported R3's low back was hurting terribly at that time. R3 stated that R3 needed R3's brace back on. (R3 pointed to a back brace in the chair approximately two feet from the recliner.) R3 repeated R3 cannot put the brace on by R3's self. V13 stated V13 will get R3 some pain medication and get the back brace back on. V13 RN stated to this surveyor that V13 is not sure if therapy took the brace off. V13 reported R3 had therapy this morning. R3 stated R3 did have it on when R3 did therapy today. A CNA took it off when the unidentified CNA transferred R3 to the recliner. R3 thought R3 was going to put it back on before the unidentified CNA left R3's room. R3 stated the CNA was busy, and left so fast, R3 did not have time to remind the CNA. This has happened several times. R3 stated R3 usually reminds staff to put the back brace back on. R3 wants to heal so, R3 doesn't have pain like this when R3 goes home. V13 RN then stated Absolutely, you (R3) are supposed to be wearing your brace. We (staff) want to make you (R3) stronger and hope those fractures get better so, your (R3) pain diminishes, and you can reach your desired goal to go home. I (V13) don't know about the boot. I'll check into that. V13 RN stated to R3, You absolutely need to wear your back brace when you are out of bed, even when you are seated in the recliner. This is a surgical shoe. I (V13) will find out about the wrap to your ankle. This is not a compression wrap, and it is too high up to be supporting your ankle. I'm (V13) not sure what's under there. I (V13) don't know anything about a tear in your (R3's) skin. I (V13) will check the treatment orders when I'm done passing medications. I (V13) will be back to assess the skin under the dressing on your shin. I (V13) will find out about the boot while I'm gone. V13 then searched in R3's closet and drawers and stated V13 did not see a boot. V13 then returned to V13's medication cart. V13 reviewed R3's computer record and said R3's physician orders, and care plan documented that R3 is always supposed to wear R3's back brace. It also says in the physician orders that R3 is supposed to have a boot. That makes sense, R3 has a right ankle fracture. V13 stated V13 will review all the orders and notes and get back to R3 and see where R3's boot is. It's obviously not in R3's closet. V13 stated V13 will make sure R3 has R3's back brace on, immediately. V13 saw R3's back brace in the chair across from R3's recliner. On 5/5/26 at 12:55 pm, V11 Director of Therapy/ Physical Therapy Assistant (PTA) stated V11 PTA completed R3's therapy this morning. V11 stated at that time R3's back brace and surgical shoe were on. When R3 had completed therapy, both R3's back brace and surgical shoe were on. V11 stated R3 is weight bearing as tolerated and R3's back brace is supposed to remain on, anytime R3 is out of bed. As far as the boot on R3's right foot, R3 was wearing a surgical shoe. V11 stated V11 can show in the notes from the hospital, R3 is to have the surgical shoe, on at all times, with ambulation and transfers. R3 had R3's surgical shoe on during therapy. R3 came back from the hospital with the surgical shoe, not a boot. The orthopedic surgeon is who ordered this. V11 stated (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	V11 will get more information, to confirm orders. On 5/5/26 at 1:10 pm, V12 Certified Nursing Assistant (CNA) stated R3 came back from therapy today, and V12 transferred R3 to R3's recliner. V12 stated that V12 didn't know R3 had to wear R3's back brace all the time. V12 thought R3 would be more comfortable in the recliner with it off. V12 reported V12 removed the brace and pivot transferred R3 to the recliner. R3 seemed okay. As far as V12 knows, R3 doesn't have to wear the back brace all the time. V12 stated that no one has ever told V12 that the brace should be always worn when out of bed. V12 stated that V12 never looked at R3's care plan. V12 stated It's not like we have time to look at all the residents' care plans. As far as R3 wearing a boot, R3 wears an orthopedic shoe. V12 stated V12 has never seen a boot in R3's room, but V12 stated V12 will look for one. R3 is alert and oriented back to R3's usual self. When R3 came back from the hospital after R3's fall, R3 was very confused. V12 stated V12 worked the day R3 fell. When V12 found R3 on the floor at the end of R3's bed that day. R3 said R3 was going to the bathroom when R3 fell. V12 had taken R3 to the bathroom that morning between 6:15 am and 6:45 am because V12 got R3 up for breakfast. Breakfast is served at 7:00 am. Later that morning, when R3 fell R3 did not remember hitting R3's head. Since no one witnessed the fall, neuros (neurological assessment) were done anyway. The nurse did those, and V12 did vital signs (blood pressure, pulse, and respirations). R3 said R3's back was really hurting, but R3 did not mention R3's ankle. Though R3 had complained of back pain after back surgery when R3 first got admitted here on 3/20/26. You could tell by looking at R3's face the pain R3 had when R3 fell was worse. It brought tears to R3's eyes; R3 was hurting so much. V12 stated V12 stayed with R3 until the ambulance came.On 5/6/26 at 3:55 pm, V3 Medical Director stated R3's TLSO (back) brace should be worn, at all times, when R3 is out of bed. V3 confirmed that order includes when R3 is up in R3's recliner and during R3's therapy. V3 confirmed that also R3 required the compression wrap around R3's fractured right ankle and the surgical shoe R3 came from the hospital wearing. V3 also stated These, were ordered to keep R3 as comfortable as possible, until R3 has R3's orthopedic follow-up. Then, the plan may change, based on their findings.On 5/6/26 at 4:40 pm, V9 Licensed Practical Nurse (LPN) stated V9 entered the orders for R3's brace, and R3's ankle boot. V9 also did the assessment when R3 returned from the hospital. R3 did have a compression wrap around R3's ankle, but V9 didn't see an order for that on the discharge papers, received from the hospital. V9 stated that staff doesn't get all the paperwork like the staff used to. R3 had a surgical shoe on, but V9 thought that was considered a boot, when V9 wrote the order. V9 reported that V9 thought R3's TLSO brace was to be worn anytime R3 was out of bed. After V9 talked to the hospital nurse, V9 thought that nurse said the TLSO (back brace) was to be worn just as needed (PRN).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a safe environment, free of an accident hazard for one (R1) of four residents reviewed for falls on the sample list of four residents. R1's fall resulted in a hand laceration that required emergency medical treatment of 15 sutures to repair.Findings include:R1's most recent Diagnoses sheet documents the following: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, and Laceration of Superficial Palmar Arch of Right Hand, Initial Encounter.R1's most recent Minimum Data Set (MDS) documents the following: Brief Interview of Mental Status (BIMS) score of five out of a possible 15, indicating severe cognitive impairment.R1's same MDS documents R1 required partial/moderate staff assistance with the following: Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Toilet transfer: The ability to get on and off a toilet or commode.R1's same MDS documents: R1 had had two falls with no injury during the look back period of the assessment.R1's Care Plan dated 3/12/26 updated 3/29/26 post-fall documents the following:R1 requires use of a wheeled walker for mobility and assistance of one for safety.R1's same care plan documents: R1 is at risk of falling related to recentillness/hospitalization, new environment, history of falls, cognitive status, and impulsivity.R1 is non-compliant with transfer and ambulation program. R1 has a goal to have decreased risk for injury related to falls this quarter which was established on 03/29/2026 (post fall). Staff in-serviced to place R1's walker within reach.R1's Fall Event Progress Notes dated 3/29/2026 at 05:50 PM, documents the following: R1 was seen ambulating to restroom in R1's room without walker with pants lowered to knees/ankles. R1 had on slipper socks at time of incident. V7 Certified Nursing Assistant (CNA) began approaching R1 but could not reach R1 in time to prevent fall. R1 fell to R1's buttocks. R1 attempted to grab the bathroom door handle upon falling. Large laceration to inner right hand. Pressure applied. V3 Medical Director was notified. Orders received to send R1 to Hospital emergency room for evaluation. EMS (Emergency Medical Service/Ambulance) notified of incident, R1's condition and need for transfer to emergency room (ER) for evaluation. V28 (R1's) Family Member/Power of Attorney (POA), were notified of incident and R1's expected transfer to ER. Called report to Hospital Emergency Department to unidentified Registered Nurse (RN). R1 transported to Hospital ER via EMS.R1's Hospital emergency room Record dated 3/29/26 documents R1 had a fall at the facility resulting in R1's right hand laceration which required the following emergency medical treatment:Right hand X-Ray, Right hand15 suture laceration repair, a Tetanus-Diphth-Acell Pertussis 0.5 milliliter (ml) injection with Lidocaine HCl 10 ml.R1' s Progress Note dated 3/29/2026 at 09:33 PM documents the following: R1 returned to facility via family transport. Orders to start Doxycycline Hyclate (antibiotic). Sutures to right hand. Resident alert, no change in mental status, vital signs obtained and recorded. No complaint of pain at that time. Assisted with bedtime care and assisted to bed. Left upper extremity elevated on pillow (R1's right hand was injured, not her left). Dressing was Clean, Dry and Intact.The facility Illinois Department of Public Health Long-Term Care Facility & 11D - Serious Injury Incident and Communicable Disease Report documents the following: R1 whom is a [AGE] year old female who resides on the Memory Care Lane Fitness for the Mind unit, sustained a fall on 3/29/2026 around 5:00pm. R1 has a past medical history of NSTEMI (Heart Attack), Unspecified Dementia, Depression, and GERD. R1 has a BIMS score of five. On 3/29/26, R1 was ambulating to the restroom without R1's walker with R1's pants lowered to R1's knees. R1 began falling to R1's bottom and attempted to grab the side of the door to prevent the fall. When R1 grabbed the side of the door, R1's hand went down onto the metal where the lock was, and it cut R1's hand open. Medical Doctor and Power of Attorney (POA) were notified. R1 went to the ER for evaluation and received 15 sutures and an antibiotic. V1 Administrator/Licensed Practical Nurse (LPN) had V4 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Maintenance Director inspect the door for splinters and sharp edges. As a precaution the door latch was filed down along with the edges of the door being sanded down. (During observation and interviews, as noted below, V4 Maintenance Director completed his precautionary intervention to R1's bedroom door. It was determined that R1 and R4's bathroom door not bedroom door, that caused the laceration).The note attached referred to above by V1 Administrator, documents the following: On the morning of 3/30/2026, it was reported to V4 Maintenance Director that a R1 had fallen in room. Upon being informed that the resident had received lacerations to the hand from attempting to grab the door edge to keep from falling. V4 inspected the door, door edge, and door handle for splinters and sharp edges. As a precaution the door latch was filed down along with the edges of the door being sanded as well.R4 (R1's previous roommate) still resides in the room R4 shared with R1. R4's current Diagnosis sheet documents R1's diagnoses include Unspecified Dementia, With Anxiety.R4's MDS dated [DATE] documents R4's BIMS score as three out of a possible 15, which indicates severe cognitive impairment.R4's Care Plan dated 2/27/26 documents R4 is at risk for falling related to the diagnosis of Dementia. R4 requires use of a wheeled walker for mobility.On 5/5/26 at 10:25 am, V4 Maintenance Director stated that V4 did not have a work order to replace or repair R1's bedroom door. V4 stated V4 heard about R1's door in a morning meeting. V4 stated V4 assessed R1?s bedroom door and found no sharp areas on R1's bedroom door. V4 stated V4 filed down the bedroom door metal plate and door edges anyway as a precaution since R1's roommate R4 continues to reside in R1's previous room. (The bathroom door was not addressed.)On 5/6/26 between 10:00 am and 10:30 am, V4 Maintenance Director and this surveyor toured the Memory Care locked unit and observed all Memory Care unit multiple bedroom doors for any potential accident hazards. V4 confirmed several wooden bedroom doors had impairments that could result in splinters and could benefit from a sanding process to prevent any injury. There were no sharp metal components identified on the bedroom doors. R1 and R4's shared bedroom door (not bathroom doors identified below as the cause of R1's injury) was confirmed to have been sanded on the metal latch plate and outer edges of the wood door were smooth to the touch. The bathroom doors on the unit were not observed during this tour with V4.As V4 Maintenance Director left the Memory Care Unit, this surveyor was informed by V5 Memory Unit Director as follows: It was not (R1's) bedroom door (R1) got cut on. It was (R1's) bathroom door. V5 then walked into R1's (previous room-no longer resides in the facility) where R4 continues to reside. V5 identified the area of the door that R1 had cut R1's hand on. The doorknob lever metal cover measured approximately three and a half inches in circumference, was detached from the wood door and hanging over the approximately five-inch-long lever-type door handle. The detached metal cover exposed the inner metal components of the doorknob lever. The three and a half inches in circumference metal cover had sharp kitchen knife blade edges. V5 stated Maintenance is aware. I thought this had been fixed. It has not been fixed since (R1's) fall, I can see that. It is obviously not safe. On 5/6/26 at 10:45 am, V1 Administrator and V4 Maintenance Director were in the Administrator's office. V4 stated V4 had no idea it was R1's bathroom door that caused R1's laceration to R1's hand. V4 stated that this was miscommunication. V4 said V4 thought it was the bedroom door. V4 did not do any maintenance on the bathroom door. V4 also stated V4 would walk back down to the Memory Care unit and look at the bathroom door. V1 Administrator/Licensed Practical Nurse then stated We knew it was the bathroom door. I (V1) thought it was repaired. Yes, please go look at that door and get it repaired.On 5/6/26 at 10:50 am, V4 Maintenance Director walked back to Memory Care unit and confirmed that R1's bathroom door had a metal, circular plate that had slid down over the lever type door handle. V4 confirmed the metal ring, plate cover had sharp edges. V4 stated There was no work order turned in for this. I (V4) misunderstood when I (V4) was told to go look at the (R1's) door and repair it. I did not do any repairs to this (R1 and R4) bathroom door. I (V4) will have to replace the whole door handle. As you can see, it's all very sharp around the edges of this metal. The gears are exposed, which could lead to an additional injury for somebody else. I (V4) will get this fixed immediately.On 5/6/26 at 11:50 am, V7 Agency Certified Nursing Assistant (CNA) stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	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 - Actual harm Residents Affected - Few	V7 was in R1's room taking care of R4 (R1's roommate). R1 came into the room and told V7 that R1 needed to urinate. R1 had on pants all day, that were too long and hanging past R1's feet. Night shift had R1 up (completed morning care) when V7 came in that morning. Staff had to pull up R1's pants several times that day. V7 told R1 to wait just a minute, to let V7 finish getting R4 (R1's) roommate into R4's night clothes. V7 did not actually see R1 fall. V7 stated V7 was kind of turned sideways. V7 looked back at R1 when R1 screamed out. R1 was mostly on the ground, kind of holding onto the bathroom door. V7 saw immediately that R1 cut R1's hand. V7 stated V7 is sure that the bathroom door handle cut R1's hand. The door handle has been broken for months. Every time V7 works on the Memory Care unit, V7 would have to slide that metal ring-thing up to the wood but it doesn't stay. It slides down every time you pull down the handle. It still was not fixed yesterday when V7 worked. When R1 cut R1's hand, V7 grabbed a towel and applied pressure to stop the bleeding. V16 Agency CNA and another agency CNA saw what was going on and went to get the nurse. V15 Licensed Practical Nurse/LPN called an ambulance and V7 stayed with R1 to comfort R1 and continued to apply pressure until the ambulance came. When R1 came back from the hospital R1's hand was wrapped up. V7 was told R1 had to get stitches. R1 continued to walk all over the place and never acted like she was hurting or anything. Since then, R1 got pneumonia and ended up in the hospital.On 5/6/26 at 10:40 am, V20 Licensed Practical Nurse (LPN) stated V7 took care of R1 after R1 fell. V20 wasn't there when R1 fell and cut R1's hand. Part of R1's bathroom door handle was loose for a while before R1 got hurt. V20 heard that is what caused R1's laceration. V20 stated V20 is not sure if anyone turned in a work order. V20 didn't know it was still broken. As far as R1, V20 stated that V20 knows that R1's hand remained wrapped most of the time. V20 did treatments when it was ordered. R1's hand did not seem to bother R1. R1 tried to use R1's right hand all the time. R1 did not appear to be in any pain related to that. Occasionally R1 would say it was tender.On 5/6/26 at 2:05 pm, V16 Agency Certified Nursing Assistant (CNA) confirmed V16 went to get the nurse when R1 fell and cut R1's hand on the bathroom door handle. V16 stated the bathroom door handle had not been right for a long time. The metal piece would just drop down onto the door handle.