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	06/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to honor residents' right to dignity by failing to provide timely toileting needs for a resident and by staff talking amongst themselves throughout residents' meal service, while providing feeding assistance to residents. These failure affected seven residents (R5, R27, R30, R41, R46, R62 and R80) out of 35 residents reviewed for dignity on the sample list of 35. Findings Include: 1.) On 6/4/24 at 11:30 am, R62 stated she uses a bedpan. Staff has to help her, and she waits for long periods to go, and has to hold it. If they don't come quick enough R62 (voids of bowel and bladder) in the bed, then staff have to clean her up. R62's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents R62 is always continent of bowel and bladder. R62's Care Plan dated 05/05/2024 documents the following: (R62) requires assistance of 2 (two) staff for transfers, ambulation, and bed mobility due to decreased strength. Category: Activities of Daily Living Functional Status/Rehabilitation Potential The same Care plan documents: (R62) will ambulate to bathroom, in her room utilizing staff assist x 2 (x/times two staff) and FWW (front wheeled walker). On 6/5/24 at 11:20 am R62 was lying in a bariatric bed. V62 stated she cannot reposition herself without staff assistance. R62 then stated I really hate to lay in (bladder and bowel excretions). It has happened repeatedly where I am left laying in it. I haven't wet the bed since I was a child. This is terribly humiliating. I can't tell you how bad it makes me feel. R62 also stated I have told the CNA's and nurses that this is unacceptable. It falls on deaf ears. I have had to wait close to an hour, dirty (soiled in incontinence). On 6/6/24 at 12:45 am V1, Administrator/ Registered Nurse stated V1 is aware R62 has verbalized Certified Nursing Assistants have delayed answering R62 call light. V1 also stated I don't think anyone would want to lay in bed soiled, for any length of time. Yes, this is a dignity issue. The facility policy Call Light dated revised: January 2004 documents the following: (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

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 06/07/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Objectives: 1. To respond to resident's request and needs. Equipment: 1. Functioning call light. Procedure: Key Points: 1. Answer call light promptly. 2. Knock before entering room. 3. Turn off call light. 4. Listen to resident's request. Do not make him/her feel that you are too busy to help. 5. Respond to request. If item is not available, or request questionable, get assistance from nurse. Return to resident with prompt reply. 2.) R5's Minimum Data Set (MDS) dated [DATE] document R5 has severe cognitive impairment. R27's MDS documents dated 5/22/24 R27 has severe cognitive impairment. R30's MDS dated also 5/22/24 documents R30 has severe cognitive impairment. R41's MDS dated [DATE] documents R41 has severe cognitive impairment. R46 MDS dated [DATE] documents R46 has severe cognitive impairment. R80's MDS dated [DATE] documents R80 has severe cognitive impairment. On 6/5/23 at 12:12 PM - 12:20 PM V10, MDS Coordinator/Licensed Practical Nurse (LPN) sat down to provide feeding assistants to R46. V10, talked to V13, Certified Nursing Assistant (CNA) who was providing feeding assistance to R41, and V16, CNA was providing feeding assistance for R46. V10, MDS Coordinator/LPN, V13 CNA and V16 CNA engaged in conversation with each other about their off-work activities. V10, V13 and V16 would intermittently pause from personal conversations to give short directions to the residents, (i.e drink, open your mouth, bite). R5 slept at the table after limited offers by V10, to take a bite of food. On 6/5/24 at 12:25 PM -12:30 V13, CNA and V16, CNA remained at the first table providing feeding assistance. V16, CNA was assisting R46. V13, CNA continued to assist R41. R5 remained asleep at the table. At a second table in the main dining room, approximately, six feet away from the first assisted dining table, V9, Registered Nurse (RN), was providing assistance to R30, and V15, CNA was feeding R80. V8, CNA, V9, RN, V15, CNA talked across the room to the staff at the first table still assisting residents to dine. The staff were loud and spoke minimally to the residents and continued to speak of events outside/unrelated to the facility or resident care. On 6/5/24 at 12:40 PM V10, LPN acknowledged staff were engaged in personal conversations and should have been talking to the residents. (continued on next page)

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 06/07/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) On 6/6/24 at 12:20 PM -12:35 PM at the first table, in the main dining room V11, CNA was providing feeding assistance to R46. V27, CNA was providing feeding assistance to R5, V9 RN was providing feeding assistance to R41, and V10, LPN was providing feeding assistance to R27. All staff at the first table were minimally interacting with their respective resident. Staff discussed outside of work family activities with short directions given to the residents to open their mouth, take a drink, swallow etc. while talking about events outside of work. On 6/6/24 at 12:45 am V1, Administrator/ Registered Nurse acknowledged it is a dignity issue for staff to engage in conversation unrelated to work. Staff should be engaging in conversations with the residents. The facility Residents' Rights Pamphlet revised November 2018 documents the following: for People in Long-Term Care Facilities documents the following: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal laws. and Your rights to dignity and respect, * You have a right to make your own choices. * Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. * Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source.

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 06/07/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41970 Based on interview and record review the facility failed to report an allegation of verbal and physical abuse of a resident by a staff member to the Abuse Coordinator. This failure affects one (R1) resident reviewed for abuse on the sample list of 35. Findings include: R1's undated Face Sheet documents R1's medical diagnoses of Postural Kyphosis, Hypertension, Anxiety Disorder, Altered Mental Status, Dysuria, Overactive Bladder, Open Angle Glaucoma, Corneal Edema and Macular Degeneration. R1's Abuse Investigation dated 4/12/24 documents V29 (R1's Power of Attorney/POA) alleged that V28 Certified Nurse Aide (CNA) was 'rough' with R1 during cares, yelled at and was rude to R1 and left R1 in wet clothes after providing a shower to R1. On 6/6/24 at 11:50 AM V1 Administrator stated V1 was made aware of this incident on 6/6/24. V1 Administrator stated I never knew anything about this. It was not reported because this is the first, I am hearing about it. I will report it now. On 6/6/24 at 12:00 PM V2 Director of Nurses (DON) stated V28 Certified Nurse Aide (CNA) was given a written warning after R1's family complained about his care for R1. V2 stated there was an investigation done at that time and V28 CNA was suspended. V2 DON stated V28 was also on vacation, so the suspension overlapped V28's vacation time. V2 DON stated V28 was not in the facility until the investigation was completed. The facility policy titled 'Abuse Prohibition and Reporting' revised 11/28/2019 documents the facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If the allegation involves the Administrator, then the facility employ or agent should immediately report the matter to the facility Director of Nurses (DON).

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 06/07/2024
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to follow physician orders one (R339) resident reviewed for infection in the sample list of 35 residents. Findings include: R339's undated Face Sheet documents R339's diagnosis as: Enterocolitis due to Clostridium Difficile, not specified as recurrent. R339's Care Plan dated 5/24/24, documents administer antibiotics as ordered. R339's Discharge Documentation dated 5/23/24, documents R339 discharged on [DATE]. This same discharge documents R339's Primary Discharge Diagnosis as Clostridium Difficile. R339's Patient Discharge Instructions dated 5/23/24, documents Fidaxomicin 200 milligrams (mg) oral tablet 1 tablet oral two times a day for ten days; last dose 5/23/24 AM, next dose 5/23/24 PM. R339's Medication Administration Record (MAR) dated 5/23/24 - 6/7/24, documents Dificid (fidaxomicin) 200 mg tablet by mouth twice a day. This same MAR documents this antibiotic as not given on 5/23/24 PM dose as it documents on the discharge instructions to be given; not given on 5/26/24, twice a day; and 5/27/24 not given the AM dose. On 6/7/24, V3 Registered Nurse (RN) stated it look like Dificid (fidaxomicin) was not given to R339 on 5/23/24, PM dose, not given at all on 5/26/24, not given on 5/27/24 AM dose, not given on 5/29/24 AM dose. V3 stated the nurses should follow the physician orders and give medications as ordered. The facility's Medication Administration Policy dated Revised 2/04, documents to provide the resident with medications deemed necessary by the physician to improve/stabilize specified diagnoses of the resident.

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 06/07/2024
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to prevent cross contamination during urinary catheter care for one (R55) resident out of four residents reviewed for Catheter Care in a sample list of 35 residents. Findings include: R55's undated Face Sheet documents R55's medical diagnoses as Parkinson's Disease, Malignant Neoplasm of Prostate, Bladder-Neck Obstruction, Emphysema, Macular Degeneration, Muscle Wasting and Atrophy, Weakness, and history of Traumatic Subdural Hemorrhage with loss of conscious and Shortness of Breath R55's Physician Order Sheet (POS) dated June 2024 documents a physician order to provide urinary catheter care every shift. R55's Minimum Data Set (MDS) dated [DATE] documents R55 as cognitively intact. This same MDS documents R55 as dependent on staff for bathing, personal hygiene, and toileting. On 6/6/24 at 10:30 AM V11 Certified Nurse Aide (CNA) completed urinary catheter care for R55. V11 CNA wore the same pair of gloves through the entire procedure. V11 CNA did not change gloves nor use hand hygiene after contaminating gloves with stool and then cleaning R55's urinary catheter tubing. V11 CNA swiped back of V11's Right Hand in R55's stool causing visible layer and streaks of stool on back of V11's Right Hand. V11 CNA then used contaminated gloves to provide urinary catheter care for R55. On 6/6/24 at 10:40 AM V11 Certified Nurse Aide (CNA) stated V11 should have changed gloves after providing bowel incontinence care and catheter care for R55. On 6/6/24 at 11:00 AM V9 Infection Preventionist (IP) stated hand hygiene is an important part of reducing the risk of infections. V9 IP stated staff should always change gloves when gloves become contaminated. V9 IP stated R55 could be at a higher risk of infection due to improper urinary catheter care.

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 06/07/2024
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observations, interviews, and record review the facility failed to maintain and store respiratory equipment in a clean sanitary manner, off the floor and failed to date respiratory equipment when changed. These failures affected four of seven residents (R8, R30, R33, R55) reviewed for respiratory/oxygen on the sample list of 35. Findings Include: The facility's Oxygen Therapy policy dated 3/16/17 documents it is the policy of the facility to provide a source of oxygen to persons experiencing an insufficient supply of oxygen. The humidifier bottles will be attached to the tank flow meter. Oxygen set-up (cannula/mask, tubing) must be exchanged every seven days. On 6/6/24 at 12:30 PM V3 Registered Nurse/Nurse Manager confirmed respiratory equipment should be stored in a sanitary way (a bag) in order to keep tubing and masks off of the floor and other surfaces. V3 also confirmed oxygen humidifier bottles should be off the floor and connected to the oxygen concentrator. V3 also confirmed nebulizer masks, tubing and nasal cannula tubing should be dated with the date it was last changed. 1) R8's Face Sheet dated June 2024 documents R8 is diagnosed with Pneumonia and Bronchitis. R8's Physician Order Sheet dated June 2024 documents an order for Oxygen 2-4 liters per nasal cannula as needed for shortness of breath. On 6/05/24 at 12:37 PM R8's oxygen concentrator was in her room with oxygen tubing attached. There was no date on the tubing and tubing was laid over the bed and bed frame with no bad available for sanitary storage. 2.) R33's Face Sheet dated June 2024 documents R33 is diagnosed with Pneumonia, Shortness of Breath, and Chronic Obstructive Pulmonary Disorder. R33's Physician Order Sheet dated June 2024 documents an order for Oxygen at 2 liters per nasal cannula continuously for Shortness of Breath. On 6/05/24 at 12:35 PM R33's oxygen concentrator was in her room with tubing attached. The tubing was on the floor and bed with no bag available for sanitary storage. 41970 3.) R55's undated Face Sheet documents R55's medical diagnoses as Parkinson's Disease, Malignant Neoplasm of Prostate, Bladder-Neck Obstruction, Emphysema, Macular Degeneration, Muscle Wasting and Atrophy, Weakness, and history of Traumatic Subdural Hemorrhage with loss of conscious and Shortness of Breath (continued on next page)

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 06/07/2024
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55's Physician Order Sheet (POS) dated June 2024 documents a physician order for R55 to use Two liters of Oxygen per nasal cannula continuously. R55's Minimum Data Set (MDS) dated [DATE] documents R55 as cognitively intact. This same MDS documents R55 as dependent on staff for bathing, personal hygiene, and toileting. On 6/6/24 at 10:40 AM R55 was lying in bed wearing his nasal cannula connected to R55's Oxygen humidifier bottle. R55's Oxygen humidifier bottle was sitting on the floor next to R55's Oxygen Concentrator. R55's floor was littered with multiple pieces of small debris and dust. On 6/6/24 at 12:40 PM V9 Infection Preventionist confirmed R55's Oxygen humidifier bottle was sitting on R55's dirty floor. V9 IP stated all Oxygen supplies should be off of the floor and maintained in a 'more hygienic way'. V9 IP stated R55's Oxygen concentrator has a specialized area to contain the humidifier bottle but that the strap to hold in the humidifier bottle had broken. R30's undated Face Sheet documents R30's medical diagnoses as Dementia, Respiratory Distress, Wheezing, Hypoxemia, Shortness of Breath, and Dyspnea. 4.) R30's Physician Order Sheet (POS) dated June 2024 documents a physician order for Albuterol Sulfate 0.083% solution for nebulization; 2.5 milligram (mg) /3 milliliter (ml) per vial. Give one vial per inhalation every four hours as needed. This same POS documents a physician order to change the Nebulizer tubing every two weeks. On 6/4/24 at 11:00 AM R30's nebulizer face mask was dated 3/10/24 and sitting on top of a dirty sock on top of R30's bedside dresser. R30's nebulizer face mask was not in a bag. On 6/6/24 at 1:00 PM V3 Nurse Manager stated all Nebulizer tubing should be placed in a plastic bag when not in use.

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 06/07/2024
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32172 Based on interview and record review the facility failed to complete Psychotropic Medication Assessments for two of five (R43, R343) residents reviewed for Unnecessary Medications in the sample list of 35. Findings Include: The Psychopharmacological Drug Usage Procedure dated 10/18/17 documents a Psychopharmacological Drug is a medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. Residents using psychopharmacological medications must have an initial assessment with quarterly reassessments to provide a data base for the Care Plan and Gradual Dose Reduction Program. 1. R43's Face Sheet dated June 2024 documents R43 is diagnosed with Dementia with Behavioral Disturbances and Depression. R43's Physician Order Sheet dated June 2024 documents R43 is prescribed Citalopram (Antidepressant) 15 milligrams daily and Olanzapine (Antipsychotic) 2.5 milligrams daily. On 6/6/24 at 3:30 PM V3 Registered Nurse (RN) Nurse Manager confirmed R43 has not had a Psychopathological Observation (Assessment) in the last year. 2. R343's Face Sheet dated June 2024 documents R343 is diagnosed with Depression and Generalized Anxiety. R343's Physician Order Sheet dated June 2024 documents R343 is prescribed Buspar 15 milligrams twice per day and Citalopram 20 milligrams daily. On 6/6/24 at 3:30 PM V3 Registered Nurse (RN) Nurse Manager confirmed R343 has not had an Initial Psychopathological Observation (Assessment). R343 was admitted on the medications and should have has an assessment on admission.

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 06/07/2024

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41970 Based on observation, interview, and record review the facility failed to employ a Certified Dietary Manager. This failure has the potential to affect all 80 residents residing in facility. Findings include: The facility Long-Term Care Facility Application for Medicare and Medicaid dated 6/04/2024 documents 80 residents reside in the facility. On 6/4/24-6/7/24 through daily rounding in the dietary department there were no observations made of a Certified Dietary Manager. On 6/4/24 at 11:50 AM facility kitchen staff were carrying out the daily dietary duties, plating and serving lunch meal and preparing foods for the next meal. On 6/4/24 at 11:55 AM V7 Dietary Aide stated the facility has not had a dietary manager in 'almost a year'. On 6/5/24 at 9:45 AM V1 Administrator confirmed the facility does not have a Certified/Dietary Manager. V1 stated the role has been empty for six months. V1 stated the facility has made an offer to a perspective DM but has not hired anyone yet. V1 stated the Registered Dietician (RD) is onsite monthly and reviews resident charts remotely every week. V1 stated the RD is not onsite full time. V1 Administrator stated the facility does not have a policy that states there must be a Certified Dietary Manager, but facility is supposed to have a Certified Dietary Manager and does not.

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 06/07/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to provide meals at a palatable temperature for two residents (R51, R52) out of two residents reviewed for meal service in a sample list of 35 residents. Findings include: The facility dietary spreadsheet titled 'Week at a Glance Week One' documents the lunch meal for 6/5/24 consisted of beef cutlet with gravy, baked potato with sour cream and margarine, copper penny salad, bread and margarine, Jello cake with whipped topping and a beverage. 1.) R51's Minimum Data Set (MDS) dated [DATE] documents R51 as cognitively intact. R51's Physician Order Sheet (POS) dated June 2024 documents a physician order for a regular consistency diet. On 6/5/24 at 12:29 PM R51 stated the food is cold. R51 stated By the time the food gets to my room it is cold. I don't like eating in the dining room like cattle. The gravy on today's meat was ice cold. I tried one bite and that was enough. On 6/5/24 at 12:00 PM V24 walked R51's lunch meal from holding bin sitting at entrance of hall to R51's room (four rooms down from holding bin) without a cover over food. On 6/5/24 at 12:30 PM R51 was sitting in her recliner chair in her room. R51's ate approximately 10% of her lunch. R51 had taken one bite out of her beef cutlet with gravy. 2.) R52's Minimum Data Set (MDS) dated [DATE] documents R52 as moderately cognitively intact. R52's Physician Order Sheet (POS) dated June 2024 documents a physician order for a regular consistency diet. On 6/5/24 at 12:00 PM V24 walked R52's lunch meal from holding bin sitting at entrance of hallway to R52's room (five rooms down from holding bin) without a cover over food. On 6/5/24 at 12:32 PM R52 was sitting in her wheelchair in her room. R52 ate approximately 25% of her lunch meal. R52 had taken two bites out of her beef cutlet with gravy. On 6/5/24 at 12:33 PM R52 stated My food is usually cold. That gravy was as cold as ice. I don't eat cold food. They (staff) should know better. On 6/5/24 at 12:40 PM V24 [NAME] stated the staff do not cover the residents food trays when delivering the meals to the residents. V24 stated That would be a good idea. There are usually some residents who complain the food is cold. (continued on next page)

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 06/07/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 2:45 PM V3 Nurse Manager stated the resident's meal trays should be covered when the staff are carrying the food trays from the holding bin to the resident rooms. V3 stated the food would likely be cold if it is not kept covered. V3 Nurse Manager stated I don't think there is a policy on this, but it would just make sense. That way the residents would complain less about getting served cold food.

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 06/07/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to serve a modified diet as ordered for one (R41) of six residents reviewed for dining on the sample list of 35. Findings include: R41's Minimum Data Set, dated dated dated [DATE] documents R41 has severe cognitive impairment. R41's Physician Order Sheet documents R41's diet order start date was 7/22/22 as follows: Diet is to be liquidized with nectar thick liquids. On 6/5/24 at 12:00 PM, R41 being fed by V13, Certified Nursing Assistant (CNA). V13, CNA feed R41 by pouring R41's pureed liquidized foods by nosey cups into R41's mouth. The pureed food was pureed then thickened to a nectar consistency. R41's meal consisted of a beef cutlet with gravy, mashed potatoes and strawberry cake, and thickened nectar consistency beverages. R41's also had watered down-like tomatoes soup, un-thickened. V13, CNA fed R41 the watered down like tomatoes soup via a nosey cup. R41 started coughing, immediately and repeatedly. V10, Licensed Practical Nurse/Minimum Data Set Coordinator who was across the table assisting another resident. V10 directed V13, CNA to 'give R41 a break'. V13 stopped feeding R41 who continued to cough repeatedly for several minutes. On 6/5/24 at 12:35 PM V13, CNA stated I stopped giving her (R41) the tomatoes soup. That is what she was choking on. It was too thin. The kitchen is supposed to thicken (R41) drinks before we serve them. On 6/6/24 at 9:38 am V24, cook stated I was training (V25, Cook) yesterday. (R41) gets tomatoes soup instead of some vegetables. (R41) is the only resident that received the tomatoes soup yesterday. (V25) prepared (R41's) soup, but I will take full responsible for not thickening it. I know it was supposed to be and I missed it when training (V25).

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 06/07/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review, the facility failed to maintain kitchen equipment in a clean sanitary condition, to prevent potential cross-contamination and potential food-borne illness and failed to dispose of outdated dry storage food products. This failure has the potential to affect all 80 residents residing in the facility. Findings include: On [DATE] between 9:05 am - 10:45 am during the kitchen tour intermittently with V23, Head [NAME] and V24, Cook. 1.) On [DATE] at 9:05 am the commercial ice machine was soiled with a built- up of rust on the bolts of the top angled door that hung inside over the ice. V24 confirmed the observation and stated, 'that needs to be cleaned.' 2.) On [DATE] at 9:08 am, the metal shelf under the commercial coffee maker containing numerous steam table pan covers. The shelf was covered in rust. V24 confirmed the observation and stated the facility has had a problem with the coffee maker leaking for a long time, and maintenance will have to look at this. 3.) On [DATE] at 9:12 am the countertop, under the commercial juice dispenser machine, had standing water under it. The shelf below the juice dispenser contained four commercial sized multi-gallon boxed containers of juices. The boxes of juice laid on top of the rusted metal shelf. V24, stated I will have to have maintenance fix that leak too. 4.) On [DATE] at 9:15 am, the commercial two door refrigerator had two, open gallon plastic container of lime juice. The plastic gallon containers document a manufacturers date to use by [DATE]. V24 stated we don't use that very often. The distributor was out of lemon juice and brought this instead. We have a lot of it in storage. We will have to get rid of it. Once opened, we have to discard food items in seven days. 5.) On [DATE] at 9:18 am, the facilities commercial grill had a three-inch side, that overhung that abutted the commercial stove. The three-inch overhang had thick, brown and black, grease-like build-up and yellow lines of thick liquid-like drips that adhered to the grease like surface. V24 stated The yellow (substance) is from french toast I made yesterday; the rest (grease like stick build-up) has obviously been there awhile. 6.) On [DATE] at 9:22 am the approximately, three foot by two foot, back metal plate of the commercial stove, had copious amount of dark brown and black, sticky grease-like accumulation. V24 stated I will have to take a steel brush to that. It has not been cleaned for a while. We don't really have a cleaning schedule. Looks like we need one though. 7.) On [DATE] at 9:25 am the double commercial ovens had charcoal-like build-up approximately an inch in depth across the bottom of the double ovens. V24 stated. (continued on next page)

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 06/07/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	That (oven) will have to be cleaned at night, after it cools off. 8.) On [DATE] at 9:28 am the table-top, commercial can opener had a build-up of rust and metal fragments in the gears and the tip of the blade had the silver coating missing. V24 stated, We may have to just get a new can opener. That is in pretty bad shape. We usually run it threw the dishwasher. That is not doing (getting it cleaned) it. 9.) On [DATE] at 9:32 am V6, Preparation [NAME] confirmed observations in the dry storage room of the following expired items: One - opened, half used, 14.5 ounce, thick and creamy pouch of instant cheese mix manufactures use by date of [DATE], and no opened date. The dry storage room also had nine additional pouches of instant cheese mix, with the same manufactures use by date of [DATE]. There were three, opened, five-pound bags of powdered devil food cake mix manufacturers use by date of [DATE] and three unopened five-pound bags of devil's food cake with manufacturers used by date of [DATE]. V24 stated We have several cooks that do not rotate stock. I can tell you; we have used them all recently. 10.) On [DATE] at 10:45 am V23, Head [NAME] confirmed the facility commercial dishwashing station had a metal backsplash, approximately six inches high. The backsplash meets the wall, just above the dishwasher running board. The backsplash had cracked, chipped chunks of loose caulking that spanned approximately six feet across and above the dishwasher running board. V23 stated The county health already identified that a couple weeks ago and it has not been fixed yet. Adopted 08/ l 9 The facility policy Cleaning & Sanitizing Work Surfaces & Equipment Procedure documents the following: Objective: To provide guidelines to clear, clean and sanitize work surfaces and equipment. Procedure: STEP 1: CLEARING WORK SURFACES & EQUIPMENT: Clear work surface tables of food, food crumbs, dirty utensils, used cutting board, etc. Clear equipment such as grill, slicer, mixer, etc. of food and food crumbs. Take apart equipment if possible and wash and sanitize parts in 3 compartment sink. If the equipment cannot be washed and sanitized in the 3-compartment sink, follow the procedures below. The facility Long-Term Care Facility Application for Medicare and Medicaid dated [DATE] documents 80 residents reside in the facility.

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 06/07/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to prevent cross contamination during meal service by not using hand hygiene when assisting residents to eat for five (R27, R40, R46, R56, R80) residents out of five residents reviewed for Infection Control in a sample list of 35 residents. Findings include: 1.) R56's undated Face Sheet documents R56's medical diagnoses as Diabetes Mellitus Type II, Dysphagia, Anemia, History of Methylicillin Resistant Staphaureus (MRSA), History of Skin Infection, Morbid Obesity and Heart Failure. R56's Minimum Data Set (MDS) dated [DATE] documents R56 as requiring assistance with setting up her meal tray. On 6/5/24 at 11:40 AM V8 Certified Nurse Aide (CNA) used V8's bare hand to move R56's cut pieces of beef cutlet from one side of R56's plate to the other side. V8 did not use hand hygiene and was not wearing gloves. R56 then picked up her fork and ate the same pieces of beef cutlet that V8 CNA had moved with her bare hand. On 6/6/24 at 11:05 AM V8 Certified Nurse Aide (CNA) stated V8 should not have touched R56's food with her bare hands. V8 CNA stated V8 should have worn gloves or used R56's utensils to move food around on R56's plate. 2.) R27's undated Face Sheet documents R27's medical diagnoses as Alzheimer's Disease, Dysphagia, Major Depression Disorder, Chronic Pain, and Tremors. R27's Minimum Data Set (MDS) dated [DATE] documents R27 is dependent (helper does most or all of the work) on staff for assistance with eating. R46's undated Face Sheet documents R46's medical diagnoses as Alzheimer's Disease, Vascular Dementia, Dysphagia, Cerebral Infarction, Gastro-Esophageal Reflux Disease (GERD) and Vitamin Deficiency. R46's Minimum Data Set (MDS) dated [DATE] documents R46 as dependent (helper does all of the effort) with assistance in eating. On 6/4/24 at 12:20 PM V10 Licensed Practical Nurse (LPN) assisted both R27 and R46 throughout the lunch meal. V10 assisted R27 and then without using hand hygiene or Alcohol Based Hand Rub (ABHR) assisted R46 multiple times during lunch meal. (continued on next page)

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 06/07/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 12:25 PM V10 Licensed Practical Nurse (LPN) assisted R27 with eating her lunch. V10 attempted to feed R27 a bite of chocolate cake which touched R27's lips but then fell down onto V10's Left Wrist. V10 shook the piece of cake onto table, moved it towards the center of her table with her Right Hand and then V10 LPN proceeded to use her Right Hand to assist R46 with eating her meal. V10 did not use hand hygiene nor use alcohol-based hand rub (ABHR) prior to assisting R46 to eat her meal. 3.) R40's undated Face Sheet documents R40's medical diagnoses as Hereditary Spastic Paraplegia, Gastro-Esophageal Reflux Disease and Dysphagia. R40's Minimum Data Set (MDS) dated [DATE] documents R40 as dependent (helper does all of the effort) with assistance in eating. R80's undated Face Sheet documents R80's medical diagnoses as Anorexia, Alzheimer's Disease, Ventricular Premature Depolarization, Bradycardia, Dilated Cardiomyopathy and Vitamin Deficiency. R80's Minimum Data Set (MDS) dated [DATE] documents R80 as requiring moderate assistance (helper does less than half the work) for eating and oral hygiene. On 6/4/24 at 12:15 PM V8 Certified Nurse Aide (CNA) assisted R40 with eating her lunch meal. V8 CNA gave R40 a bite of food, then using both hands grabbed with table to reposition herself closer to R80. V8 then used contaminated Right Hand to pick up R80's drinking cup with palm placed directly over open top of cup and straw positioned in between V8's fingers to give R80 a drink of water. On 6/6/24 at 11:07 AM V8 Certified Nurse Aide (CNA) stated V8 should have used hand hygiene when assisting two residents (R40, R80) eating their meals at the same time. The facility policy titled 'Hand Washing Procedure' adopted August 2019 documents proper hand washing is the most effective way to reduce microorganisms to prevent the spread of infection such as Influenza and to prevent foodborne illness such as Norovirus. Facility staff should wash hands after touching clothes, face, body, or hair, after handling soiled equipment, after handling dirty dishes and after engaging in any activity that would contaminate hands. Hand antiseptic may be used AFTER washing hands and is not to be used as a substitute for hand washing.