

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Mount Vernon Countryside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 606 East IL Hwy 15 Mount Vernon, IL 62864	
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 - Few	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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to properly secure a resident's wheelchair into the facility van for 1 of 3 residents (R1) reviewed for accidents in the sample of 3. This past non-compliance occurred between 9/19/25 and 9/20/25. The findings include: R1's Face Sheet documented an admission Date of 3/1/25 and listed Diagnoses including COPD (Chronic Obstructive Pulmonary Disease), Atrial Fibrillation, Rheumatoid Arthritis, and Hypertension. A Minimum Data Set, dated [DATE] documented that R1 has moderate deficits in cognition, has impaired range of motion to both lower extremities, and requires the use of a wheelchair. R1's Care Plan with a start date of 4/15/25 and a review date of 9/23/25 documented a problem area, I am prescribed anticoagulant medication. R1's Event Report documents an event date and time of 9/19/25 at 1:27pm, description of fall, and a location of facility vehicle. Under Conclusion of root cause documents Resident's wheelchair tipped to the right side but remained in the air and buckled in the van. Resident is unsure if she hit her head but believed she did and acquired skin tear to the left arm. Sent to (local hospital) ER (Emergency Room) for further evaluation and treatment. Under Notes documents Resident returned from hospital at (5:40pm.) Started on neuros (neurological checks) at (5:45pm) pupils equal, responsive to light and accommodation. Equal grasp strength bilaterally, ROM (Range of Motion) WNL (Within Normal Limits) in all extremities. Significant bruising scattered throughout body. On right posterior calf bruises measuring 3x3.5cm (centimeter) and 2x1cm. On outer lateral right calf bruises measuring 3x3.5cm, 1x1cm, 2x0.75cm, 0.5x0.5cm and 0.5x0.5cm. On inner lateral right calf bruise measuring 3x3.5cm. On left posterior calf bruises measuring 6.5x4cm and 0.75x0.75cm. Bruise behind knee 6.5x2.5. All bruises previously mentioned were dark red in color upon assessment. On lateral outer left calf greenish-yellow bruise 5x2 (cm), then more red bruises measuring 1x1.5cm, 2.5x2.5cm, 1.5x1cm. [NAME] bruise on knee assessed at 1.5x1cm. Right upper arm pinpoint bruising measuring 11x7.5 cm, resident states was from BP (Blood Pressure) cuff at hospital. Bruise on right upper forearm measuring 5.5x2.5cm. Bruise on left hand measuring 3x5cm. Bruise behind left upper arm 5.5x3.5cm. Skin tear on anterior left forearm measuring 3x1 cm, bruise surrounding it 4.5x3cm. Skin tears below that one measuring 5x2cm and 1.5x1cm with bruise surrounding them measuring 10x3.5cm. R1's 9/19/25 ED (Emergency Department) Provider Note documented, (R1) is an [AGE] year-old female with a past history of COPD, Hypertension, A Fib (Atrial Fibrillation), Rheumatoid Arthritis and is on Eliquis who presents to the ED with complaints of hitting the back of her head and has a left forearm skin avulsion. Patient stated that she was in the wheelchair van when her wheelchair tipped backwards, and she hit the back of her head. She denies experiencing loss of consciousness, dizziness, blurry or double vision, chest pain, shortness of breath, and denies any other injury. Patient has a skin avulsion on her left forearm, bleeding is controlled, patient is neurologically intact, patient denies cervical tenderness, no spinal step offs noted, no obvious injury or deformity noted on physical exam. Clinical Impressions: Fall, initial encounter. Avulsion of skin of left forearm, initial encounter. Disposition: Discharge. Condition: Stable. On 9/30/25 at 10:35am, R1 was alert and oriented to person, place, and time. R1 stated she might be somewhat fuzzy on the details, but on 9/19/25 she was riding in the facility van when V4, Transport Staff, turned right, and R1's wheelchair tipped over to the left, but not all the way over. R1 stated she somehow sustained a skin tear to her left forearm, which was observed to be covered with a clean dry dressing dated 9/30/25. R1 stated she also thinks she hit the back of her head on something, but she is not sure what. R1 stated she has had some back pain after the incident which she thinks was from being in a sitting position on the floor of the van afterwards, but nothing requiring intervention with narcotic pain medications. R1 stated V4 was not driving fast or not in an unsafe manner. R1 stated examination and imaging at the ER showed the only injury was the skin tear. R1 stated following the incident her memory and level of functioning are baseline. R1 stated all transport staff have always been extremely safe and careful with her. When asked her if there was any issue with any of the straps not being attached properly to the wheelchair, R1 stated she had no idea if this was a factor. When asked about the Incident Report stating there was bruising to the body, R1 stated she was not sure if she sustained bruises, but it was no big deal and it was probably gone by now. When asked by the Surveyor if she would allow observation of a nursing skin assessment, she stated not today as she was tired and wanted to rest. On 9/30/25 at 11:10am, V4 stated on 9/19/25 she had taken R1 to the bank. V4 stated she had gotten R1 out of the van and into the building to do her banking, then they came back out, and she</p>		