STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Healthcare & Senior Living	2116 South 3rd Dacey Drive 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 - Few	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** 41970 Based on interview and record review the facility failed to ensure the dignity of one (R1) resident out of five residents reviewed for resident rights in a sample list of five residents. Findings include: The undated facility pamphlet titled Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long Term Care Facilities documents the facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. R1's undated Face Sheet documents admitted to the facility on [DATE] and lists R1's medical diagnoses as Lymphedema, Chronic Venous Hypertension with ulcer of lower extremity, Diabetes Mellitus Type II, Parkinson's Disease, Cellulitis of Right and Left Lower Limbs, Morbid Obesity, Chronic Kidney Disease Stage 3, Acute Kidney Failure and Chronic Congestive Heart Failure. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 as requiring supervision with bathing and putting on and removing footwear. R1's care plan intervention dated 9/19/24 instructs staff to Keep skin clean and dry. 9/19/24 Follow facility policies/protocols for the prevention/treatment of skin breakdown. R1's Skin Evaluation assessment dated [DATE] documents R1's Left Lower Extremity (LLE) Cellulitis/Venous Lymphedema wounds measuring 22.0 centimeters (cm) long by the entire circumference of R1's LLE by 0.1 cm deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment documents R1's Right Lower Extremity (RLE) Cellulitis/Venous Lymphedema wounds measuring 20.0 centimeters (cm) long by the entire circumference of R1's RLE by 0.2 cm deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment lists R1's Right Dorsal Foot open lesion measures 6.0 cm long by 6.0 cm wide by 0.1 cm deep as macerated with moderate serosanguinous drainage and R1's Left Dorsal Foot open lesion measures 8.0 cm long by 8.0 cm wide by 0. 1 cm deep as macerated with minimal serosanguinous drainage. R1's Hospital Record dated 3/16/25 documents R1 as wearing garbage bags around his legs and plastic booties, for which he is sitting and about two inches of yellow serous fluid from his legs. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:00 PM V14 Wound Nurse/Licensed Practical Nurse (LPN)/Infection Preventionist (IP) stated V14 did tell R1 he was to wear garbage bags over his lower legs to help control the mess from the drainage. V14 stated R1 would walk the halls and leave wet footprints everywhere from all the drainage in his legs. V14 stated that was the only thing she could think of to help because the facility did not have the budget to be able to re-wrap his lower legs multiple times per day. V14 stated she realizes that wasn't the best method and should have changed R1's dressings instead of putting garbage bags over his legs. On 4/3/25 at 9:47 AM R1 stated the facility told him he had to wear garbage bags over both of his lower legs to help contain all the drainage from his open wounds on his bilateral lower legs and feet. R1 stated he was told he could not come out of his room unless he wore the garbage bags. R1 stated the nurses would put plastic booties on his feet and then have him put each lower leg inside a garbage bag. R1 stated the nurses would wrap gauze around his lower leg and then tie the gauze in a knot around his leg just below his knees to help keep the garbage bag from falling. R1 stated That was embarrassing. How would you like to wear something like that. But I couldn't come out of my room otherwise. People would stare at my legs. They (facility) said they couldn't afford to keep wrapping my legs all day so that was their way of keeping the drainage off the floor. One nurse (unknown) even told me they (staff) didn't have time to keep mopping up after me.

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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** 41970 Deficiencies at this level require more than one deficiency practice statement. A. Based on interview and record review the facility failed to transcribe and implement physician ordered wound treatments, failed to ensure wound supplies were provided and treatments were completed as ordered. The facility failed to accommodate a request for physician ordered wound treatments to be supplied or changed to an alternative treatment. The facility also failed to notify the provider of the facility changing the dressing orders, not transcribing/implementing Wound Physician Assistant (PA) orders, and not notifying the Wound PA of a resident request to change wound dressing orders for one (R1) resident out of five residents reviewed for wound care in a sample list of five residents. R1 experienced pain, embarrassment and worsening of his bilateral extremity wounds resulting in a 15-day hospitalization for the treatment of his BLE wounds and infection. B. Based on observation, interview, and record review the facility failed to assess, monitor, notify the physician of a wound and failed to obtain treatment orders. The facility also failed to prevent cross contamination during wound care for one (R2) resident out of five residents reviewed for wound care in a sample list of five residents. Findings include: A. R1's undated Face Sheet documents admitted to the facility on [DATE] and lists R1's medical diagnoses as Lymphedema, Chronic Venous Hypertension with ulcer of lower extremity, Diabetes Mellitus Type II, Parkinson's Disease, Cellulitis of Right and Left Lower Limbs, Morbid Obesity, Chronic Kidney Disease Stage 3, Acute Kidney Failure and Chronic Congestive Heart Failure. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 as requiring supervision with bathing and putting on and removing footwear. R1's care plan intervention dated 9/19/24 instructs staff to Keep skin clean and dry. 9/19/24 Follow facility policies/protocols for the prevention/treatment of skin breakdown. R1's Physician Order Sheet (POS) dated December 15-31, 2024, January 1-31, 2025, and February 1-20, 2025, document physician orders to cleanse R1's bilateral lower extremities (BLE) with soap and water, apply zinc to peri wound, (Brand name dressing used to absorb wound drainage) with silver to open wounds, cover with (Brand name compression bandage system) twice per week and as needed. Once (Brand name compression bandage system) is tolerated, then change to weekly if drainage slows and dressing is intact. R1's Physician Order Sheet (POS) dated February 21-28 documents a physician order to cleanse R1's BLE with soap and water, apply (Brand name petroleum impregnated gauze) soaked gauze to open areas, (Brand name semi-rigid compression bandage), zinc oxide to peri wound then wrap with dry gauze from mid foot to high calf with compression gauze twice per week and as needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Wound Assessment and Plan dated 1/2/25, 1/9/25, 1/23/25 documents a physician order to cleanse R1's BLE, apply Zinc oxide to peri wound, apply (Brand name dressing used to absorb wound drainage) Silver followed by two- or four-layer compression wraps depending on what is available twice per week or sooner if dressings are saturated and as needed. R1's Wound Assessment and Plan dated 1/30/25 document a physician order to cleanse R1's BLE, apply Zinc Oxide to peri wounds, apply (Brand name petroleum impregnated gauze) cut to fit to open areas, cover with absorbent gauze, two- or three-layer compression wraps depending on what is available three times per week or sooner if dressings are saturated and as needed. This same plan documents R1's newly acquired Right and Left Dorsal open areas to cleanse, apply Calcium Alginate, cover with absorbent pad, and wrap daily and as needed. R1's Wound Assessment and Plan dated 2/6/25 and 2/20/25 documents a physician order to cleanse R1's BLE, apply Zinc Oxide to peri wounds, apply (Brand name petroleum impregnated gauze) cut to fit to open areas, cover with absorbent gauze, two- or three-layer compression wraps depending on what is available three times per week or sooner if dressings are saturated and as needed. This same plan documents in addition to R1's BLE dressing orders the facility is to provide (Brand name semi-rigid compression bandage) when available, Calcium Alginate and compression wraps three times per week or sooner if saturated. R1's Wound Assessment and Plan dated 3/13/25 documents a physician order to cleanse R1's BLE and bilateral dorsal feet, apply Zinc Oxide to peri wounds, apply absorbent gauze, wrap with dry gauze and then compression gauze three times per week and as needed. R1's Skin Evaluation assessment dated [DATE] documents R1's Left Lower Extremity (LLE) Cellulitis/Venous Lymphedema wounds measuring 22.0 centimeters (cm) long by the entire circumference of R1's LLE by 0.1 cm deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment documents R1's Right Lower Extremity (RLE) Cellulitis/Venous Lymphedema wounds measuring 20.0 centimeters (cm) long by the entire circumference of R1's RLE by 0.2 cm deep as macerated with heavy serosanguinous drainage that is painful to R1. This same assessment lists R1's Right Dorsal Foot open lesion measures 6.0 cm long by 6.0 cm wide by 0.1 cm deep as macerated with moderate serosanguinous drainage and R1's Left Dorsal Foot open lesion measures 8.0 cm long by 8.0 cm wide by 0. 1 cm deep as macerated with minimal serosanguinous drainage. R1's Final Culture and Sensitivity report dated 2/9/25 documents R1's Right Leg culture showed Proteus Mirabilis, Providencia Stuartii, Stenotrophomonas Maltophilia and Diptheroids. The undated facility Sign Out/Acceptance of Responsibility for Leave of Absence form documents R1 signed himself out on 3/16/25 at 9:30 PM. This same form documents R1's destination was to the hospital. R1's Nurse Progress Note dated 3/16/25 at 9:54 PM documents R1 signed himself out at 9:30 PM to go to the emergency room for bilateral lower extremity (BLE) pain. This same note documents R1 stated he can't stand the pain anymore. R1's Nurse Progress Note dated 3/17/25 at 1:44 AM documents the hospital called to report to the facility R1 was being admitted to the hospital for BLE wounds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Records document R1 had multiple ulcers stage 2 through 3 on both lower legs, the rest of the affected area on both lower legs had Moisture Associated Skin Dermatitis (MASD). This same report documents R1's dressings were saturated and R1's bilateral lower legs were weeping. R1's Hospital Record dated 3/16/25 documents R1 as wearing garbage bags around his legs and plastic booties, for which he is sitting in about two inches of yellow serous fluid from his legs. This same record documents R1's extremities show no cyanosis, claudication with +4 bilateral lower extremity and pedal, extensive weeping consistent with his Lymphedema history, multiple non-healing venous stasis wounds, macerated tissue to the Left foot and ankle. This same record documents (R1's) dressings are saturated through and he is dressed with plastic bags over his wound dressings. R1) is not getting appropriate wound management for not only his Cellulitis and nonhealing wounds but also his Lymphedema. (R1's) Bilateral lower extremities are erythematous and edematous. Multiple scattered shallow full-thickness skin loss noted. Most of the wound beds are red and moist. There is a wound on the Right Lower Leg that has a small amount of slough noted. There is a large amount of serosanguinous drainage present. Scattered areas of maceration noted. Circumference of the right calf is 51 centimeters (cm). Circumference of the left calf is 53 cm. On 4/2/25 at 8:30 AM V10 (Licensed Practical Nurse/LPN) stated R1 complained of pain on 3/16/25 to his BLE. V10 stated she administered pain medication to R1. V10 stated R1 asked for more pain medication 20 minutes later and she instructed R1 to give the pain medication time to work. V10 stated R1 reported he was 'in too much pain that he could not stand it'. V10 stated R1 would occasionally refuse dressing changes if the facility did not have the appropriate dressings. V10 stated R1 had a friend take him to the hospital that night (3/16) and he was admitted for the treatment of his wounds. V10 stated she did not have a chance to change R1's dressings that evening. On 4/3/25 at 9:45 AM R1 stated the facility did not follow the physician orders for his dressing changes to his BLE. R1 stated he had asked for V11 (Wound Physician Assistant/PA) to be called and asked for a different type of dressing and was told the facility does not have a way to contact V11. R1 stated he was told to wear garbage bags on his lower legs to catch the drainage. R1 stated the staff would use rolled gauze to wrap his leg and then use the same gauze to tie the garbage bags onto his legs so that they would stay up. On 4/3/25 at 10:20 AM V11 (Wound PA) stated the facility did not notify her of R1's request for different treatments, her dressing orders not being completed as ordered, the facility not having the correct wound supplies or that the facility was using garbage bags to contain the drainage. V11 stated R1 was alert and oriented and would sometimes refuse dressings. V11 stated the facility should have investigated why the dressings would be refused to prevent deterioration of R1's BLE wounds. V11 stated garbage bags should not have been used to contain wound drainage and would have caused harm to R1 by keeping the drainage next to the wounds and exposing R1's feet to unnecessary maceration due to sitting in wound drainage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/3/25 at 11:00 AM V14 (Wound Nurse/LPN/Infection Preventionist/IP) stated V11 (Wound PA) would see R1 weekly and change his dressing orders according to what R1 would agree to. V14 stated many time the dressing order was changed but V14 did not change the order in the computer due to being told by the corporation that R1's specific types of dressings were too costly and could not be ordered. V14 stated she did not reach out to V11 (Wound PA) to report the dressings were not ordered and that R1 had been getting the wrong dressings. V14 stated R1's wounds did deteriorate during his stay in the facility due to the wrong dressings being put on, the staff not changing R1's dressings more frequently due to cost of the supplies and not re-approaching R1 if he did refuse to see why R1 was refusing his dressing changes. B. R2's undated Face Sheet documents medical diagnoses as Morbid Obesity, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Peripheral Vascular Disease, Paroxysmal Atrial Fibrillation, Chronic Venous Hypertension, Acute Nephritic Syndrome, Lymphedema, Cellulitis and Body Mass Index (BMI) greater than 70. R2's care plan intervention dated 10/17/23 documents staff are to Monitor/document location, size, and treatment of impairment. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to Physician. R2's Physician Order Sheet (POS) dated March and April 2025 does not document a treatment order for R2's open Left Elbow wound. R2's Nurse Progress Note dated 3/24/25 documents R2 has sores on her Left Elbow/Bicep area. On 4/2/25 at 10:30 AM R2 stated she has open sores on her Right Lower Leg due to her Lymphedema. R2 stated she has blisters on her Left Elbow area that popped. R2 stated the staff have been aware of this area for about a week but have not put any dressing on yet. On 4/2/25 at 10:35 AM R2 was laying in her bed with her arms exposed, above the covers. R2's Left Elbow had two nickel sized intact blistered areas and one quarter sized open area draining clear/yellow fluid onto R2's sheets. R2's Left Elbow wounds did not have any dressing in place. On 4/2/25 at 1:15 PM V10 (LPN) and V14 (Wound Nurse/LPN/IP) completed R2's dressing change to her Right Lower Extremity (RLE) open wounds. V10 cleansed R2's RLE, applied antibiotic ointment and Calcium Alginate rope. V10 turned away from R2 to get the absorbent gauze, then turned back and saw that R2's Calcium Alginate rope had dropped onto the towel below R2's leg. R2's Calcium Alginate rope dropped directly onto the section of R2's towel that was soiled with blood and serous fluid from R2's open wounds. V10 picked up the contaminated Calcium Alginate rope and placed it again on the wound and continued to finish the dressing change. On 4/2/25 at 2:00 PM V10 Licensed Practical Nurse (LPN) stated she cross contaminated R2's open draining wound due to V10 saw the Calcium Alginate rope sitting in the wound drainage on the towel and continued to put that contaminated rope back on R2's open wound. V10 stated she should have gotten a new piece of rope. V10 stated cross contaminating an open wound could cause an infection. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/3/25 at 2:30 PM V14 (Wound Nurse/LPN/IP) stated she was informed on 4/2/25 of R2's Left Elbow open wounds. V14 stated staff should have obtained an order for a protective dressing when this area was first observed last week (3/24/25) and then gotten an order change after it opened three days ago (3/31/25). V14 stated the facility is conducting a house wide training next week on wound care, following physician orders, timely reporting of any new skin areas and other areas of concern. The facility policy titled Skin Conditioning Monitoring revised 3/16/23 documents upon notification of a skin lesion wound, or other sin abnormality, the nurse will assess and document the findings in the nurses' notes and complete a skin evaluation. The nurse will then implement the following procedure: notify the physician, obtain treatment order which includes type of treatment, location of area, frequency of how often treatment is to be performed, how area is cleansed and a stop date if needed. The facility policy titled Dressing Change revised 3/16/23 documents staff should follow the physician order for treatments.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41970 Based on observation, interview, and record review the facility failed to employ a Full Time Director of Nurses (DON). This failure has the potential to affect all 37 residents residing in the facility. Findings include: The Facility Midnight Census Report dated 4/1/25 documents 37 residents reside in the facility. On 4/1/25-4/3/25 at various times there was no DON present in the facility. On 4/1/25 at 9:50 AM V1 (Administrator) stated the facility has not had anyone in the Director of Nursing role since early February 2025. V1 stated the DON plays an important role in the quality of care every resident receives. On 4/3/25 at 1:10 PM V14 (Wound Nurse/Licensed Practical Nurse/Infection Preventionist) stated she is struggling to keep up with all her duties because she is managing programs, working the floor, the wound nurse, the infection control nurse and 'all around' person to answer questions. V14 stated having a DON would reduce some of the problems in the facility due to the DON could assist with resident concerns and monitor programs so that nothing would get missed.

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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 initiate Enhanced Barrier Precautions (EBP) for four residents (R2, R3, R4, R5) out of five residents reviewed for EBP in a sample list of five residents. Findings include: 1. R2's Care plan intervention dated 10/17/23 does not document a focus area, goal nor interventions for Enhanced Barrier Precautions (EBP). On 4/1/25 at 10:00 AM R2 does not have a sign on her door indicating she is on Enhanced Barrier Precautions (EBP). R2 does not have any Personal Protective Equipment (PPE) outside of her room or any adjacent rooms. On 4/2/25 at 10:15 AM V10 (Licensed Practical Nurse/LPN) and V14 (Wound Nurse/Infection Preventionist/IP) gathered wound supplies, walked into R2's room and stated they were ready to provide wound care for R2. V10 and V14 were not wearing gowns. On 4/2/25 at 11:05 AM V10 and V14 both stated they should have worn gowns. V14 stated R2 should have been on EBP and was not. V10 stated there was no EBP sign on R2's door so she did not think R2 needed EBP. 2. R3's Electronic Medical Record (EMR) documents R3 has open sores on both feet due to Lymphedema. R3's Physician Order Sheet (POS) dated April 2025 does not document a physician order for R3 to be placed on Enhanced Barrier Precautions (EBP) prior to 4/2/25. R3's Care plan initiated 3/7/25 does not include a focus area, goal nor interventions for EBP. On 4/2/25 at 12:30 PM R3 was sitting in his recliner chair in his room. R3's bilateral feet were wrapped with compression wraps which left toes exposed. R3's feet were resting directly on the floor. R3 was not wearing any socks or shoes. R3's floor was littered with debris and spills of food particles. R3 did not have a sign on his door indicating he is on Enhanced Barrier Precautions (EBP). R3 does not have any Personal Protective Equipment (PPE) outside of his room. On 4/2/25 at 12:35 PM R3 stated the staff will 'usually' wear gloves to change his dressings on his feet and have never worn a gown of any sort. 3. R4's Minimum Data Set (MDS) dated [DATE] documents R4 as severely cognitively intact. R4's Electronic Medical Record (EMR) documents R4 has an open Stage 3 Pressure Ulcer on her Left Heel that drains serous fluid. R4's Care plan dated 4/2/25 does not include a focus area, goal nor interventions for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 12:00 PM R4 did not have an Enhanced Barrier Precautions (EBP) sign posted on her door nor Personal Protective Equipment (PPE) supplies accessible to staff. On 4/2/25 at 3:30 PM R4 did not have an Enhanced Barrier Precautions (EBP) sign posted on her door nor Personal Protective Equipment (PPE) supplies accessible to staff. 4. R5's Medical Record documents medical diagnoses as Chronic Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), history of pressure ulcers and Staphylococcus infection and open draining Hematoma to Right Lower Extremity. R5's Care plan initiated 9/16/24 does not document a focus area, goal nor interventions to address R5's open draining Right Lower Extremity (RLE) wound nor Enhanced Barrier Precautions (EBP). On 4/1/25 at 12:05 PM R5 did not have an Enhanced Barrier Precautions (EBP) sign posted on her door nor Personal Protective Equipment (PPE) supplies accessible to staff. On 4/2/25 at 3:35 PM R5 did not have an Enhanced Barrier Precautions (EBP) sign posted on her door nor Personal Protective Equipment (PPE) supplies accessible to staff. On 4/3/25 at 1:20 PM V14 (Wound Nurse/LPN/IP) stated R2, R3, R4 and R5 should have been placed on EBP and were not. V14 stated she was not aware of EBP until 4/2/25. V14 stated she is going to research it and ensure all residents who are supposed to be on EBP will be placed on EBP. V14 stated there are other residents in the facility who would meet the same criteria but have not been on EBP. V14 stated EBP has not been monitored or tracked since the she was not aware of what EBP was. The facility policy titled Enhanced Barrier Precautions dated 4/24/24 documents Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply for residents with open wounds that require a dressing change. EBP requires use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of Multi Drug Resistant Organisms (MDRO) to staff hands and clothing. High contact care activities include wound care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds).