

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145836	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Shelbyville Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Narcotic medications are kept under a double lock system, failed to ensure medications are stored properly and failed to ensure medications remain in a locked environment. These failures have the potential to affect all 38 residents residing in the facility. Findings include: The facility daily midnight census dated 2/17/26 documents 38 residents reside in the facility. 1.R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. R6's Medication Administration Record (MAR) dated February 2026 documents Physician orders to administer Divalproex Sodium Extended Release (ER) 500 milligrams (mg) daily at 8:00 PM, Rosuvastatin 40 mg daily at bedtime, Mirtazapine 15 mg daily at 7:00 PM, Glipizide 5 mg every morning at 7:00 AM, Apixaban (anticoagulant) twice daily at 7:00 AM and 7:00 PM, Metformin Hydrochloride (HCL) 500 mg twice daily at 8:00 AM and 8:00 PM, Benadryl Allergy Extra Strength 50 mg three times per day at 8:00 AM, 2:00 PM and 8:00 PM, Gabapentin 100 mg three times per day at 7:00 AM, 2:00 PM and 7:00 PM. On 2/17/26 at 11:00 AM, R6 was sitting on the side of her bed. A clear medicine cup with nine various medications and a blue cup of water was sitting on R6's bedside dresser. On 2/17/26 at 11:10 AM, V2 (Director of Nurses/DON) displayed all nine medications found unattended in R6's room to show that three of the medications in R6's medicine cup were one tablet each of Remeron, Divalproex, Rosuvastatin which are all prescribed to administer in the evening and one tablet each of Eliquis, Metformin, Gabapentin, Glipizide and two tablets of Benadryl which are all to be administered in the morning. On 2/17/26 at 11:20 AM, V2 (DON) stated V3 (Licensed Practical Nurse/LPN) was passing medications to residents earlier this morning when V3 had to leave the facility abruptly. V2 stated she took over passing medications for V3. V2 stated she did not know if V2 or V3 passed R6 her morning medications. V2 stated R6 is known to hoard medications. V2 stated the nurses do not stay with R6 as they should, then R6 will take some of her medications and not others. V2 stated the reason R6 had some of her evening medications along with some of her morning medications is that the nurse last night (2/16/26) and the morning nurse (2/17/26) did not stay with R6 so she (R6) 'just mixed them up because she hoards them'. On 2/19/26 at 12:15 PM, V3 (LPN) stated she had started to pass one wound liquid supplement on (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	another hall for another resident on 2/17/26 when she began to feel ill. V3 stated she left immediately after that. V3 stated she did not pass any medication for any resident on the hall that R6 resides on. On 2/19/26 at 8:00 AM, V1 (Administrator) stated the nurses should stay with every resident to ensure all medications are taken. V1 stated R6 is not cognitively intact enough to administer her own medications. 2. On 2/19/26 at 7:10 AM, a facility medication cart was sitting in a resident hallway. This medication cart was unlocked. V13 (LPN) walked out of a resident room and stated Oh. That is my cart. I meant to lock it up but forgot. V13 opened the main medication drawer without a key and found that the lid to the narcotic box was not locked. V13 stated she had just opened the narcotic box for the previous resident she administered medications to and closed the narcotic box. V13 stated she thought the narcotic box would close/lock when the main drawer was closed but it did not. V13 confirmed the medications were not stored properly and the narcotics were not locked as they should be. On 2/19/26 at 11:28 AM, V14 (LPN) unlocked the narcotic box on a separate medication cart and then closed the main medication drawer. V14 then opened the same medication drawer to find that the narcotic box was not locked in place. V14 stated it is important to always lock up all the medications but especially the narcotics. On 2/19/26 at 1:15 PM, V12 (Regional Registered Nurse/RN) stated she did not know that the medication carts were not locking correctly. V12 stated she was going to call the pharmacy to have them fix and/or replace the carts. The facility policy titled Medication Labeling and Storage revised February 2023 documents compartments including but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes containing medications and biologicals are locked when not in use. Controlled substances and other drugs subject to abuse are separately locked in permanently affixed compartments. 3. On 2/17/26 at 10:20 AM, a medicine cup containing six pills were sitting on a bedside table in R47's room. This cup of medication was unsecured and accessible to others. R47 who was lying in the bed stated he did not know what kind of pills were in the cup. On 2/17/26 at 10:25 AM, V2 (Director of Nursing) stated she handed the cup of medications to R47 and left the room. V2 stated V2 did not ensure that R47 took the medication before leaving the room. The facility's Labeling and Medication Storage policy dated February of 2023 documents all medications will be stored in locked compartments.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 38 residents in the facility. Findings include: On 2/17/2026 at 9:35AM, V10 (Dietary Manager) was actively supervising dietary operations in the facility kitchen. V10 reported being the full-time manager of the facility food service (person in charge) and reported not being a clinically qualified Certified Dietary Manager (also known as Certified Food Protection Professional) or having equivalent training. V10 denied meeting the State of Illinois standards to be a food service manager or dietary manager (required in states that have their own established standards to be a food service manager or dietary manager (483.60(a) (2)ii)). V10 reported only completing a two-day course on food service sanitation (Certified Food Protection Manager) which did not include any instruction on clinical nutrition. V10 denied having any qualifications in clinical nutrition. V10 reported the facility dietician only works for the facility remotely on a consulting basis, part-time, and does not work directly in the facility. V10 denied: -being a dietician. -being a certified dietary manager. -having an associate's or higher degree in food service management or in hospitality. -having two or more years of experience in the position of director of food and nutrition services in a nursing facility setting. -being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition. -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician. -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. The Facility assessment dated [DATE] documents the facility will employ a Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services. On 2/17/2026 at 9:52AM, V10 reported food prepared in the kitchen is available for all residents in the facility to eat. The facility Midnight Census Report dated 2/18/2026 documents 38 residents reside in the facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to track and monitor employee illnesses. This failure had the potential to affect all 38 residents that reside in the facility. Findings include: On 02/18/2026 at 11:20 AM, V3 (Infection Preventionist) opened an Infection Control binder which contained resident infection logs and facility illness graphs. This binder did not contain logging of staff illness. V3 stated the facility does not document the signs and symptoms the employee is experiencing when sick or the type of illness if known. V3 stated she is only aware of nursing staff illnesses due to call offs. V3 showed a schedule where call offs were circled. V3 stated she is not aware of illnesses for other departments who work in the facility. V3 stated the facility does not formally track or monitor employee illnesses. At that time, V2 (Director of Nursing) grabbed a binder off a shelf, opened the binder, and flipped to a list from September of 2025. V2 stated this is a list of call offs of nursing staff for September. This list documented staff names and dates but did not document the type of illness or the signs and symptoms of illness the staff was experiencing. V2 confirmed that this list only contained call offs for September for the nursing staff and that this list did not document the type of illness. V2 and V3 stated this was the only documentation they had for tracking and monitoring of employee illnesses. On 2/19/26 at 1:30 PM, V1 (Administrator) stated V3 should be monitoring and tracking all staff illness and/or signs and symptoms of illness. The facility's Communicable/Contagious Diseases, Employee policy dated December of 2024 documents the facility's infection preventionist is responsible for the oversight of the staff illnesses. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 2/17/26 signed by V12 (Regional Registered Nurse) documents there are 38 residents residing in the facility.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to offer the staff COVID vaccinations and document the staff's COVID vaccination status. This failure has the potential to affect all 38 residents residing in the facility. Findings include: On 02/18/2026 at 11:20 AM, V3 (Infection Preventionist) stated the facility does not offer the staff COVID vaccinations or keep track of the staff's vaccination status. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 2/17/26 signed by V12 (Regional Registered Nurse) documents there are 38 residents residing in the facility.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a Preadmission Screening and Resident Review (PASARR) Level I for two of two residents (R6, R13) reviewed for PASRR's in a sample list of 29 residents. Findings Include: 1. R13's Medical Diagnoses List dated February 2026 documents R13 was admitted to the facility on [DATE] and had a new diagnosis of Major Depression added in November 2025. R13's Preadmission Screening and Resident Review (PASARR) Level II screening dated 12/13/24 documents a Level II screening is not indicated because there is no evidence of a serious behavioral health condition (Serious Mental Illness) however, if changes occur or new information refutes those findings the facility must submit a new Level I screening. On 3/23/25 at 9:25 AM, V12 (Regional Clinical Nurse) confirmed R13's Preadmission Screening and Resident Review (PASARR) Level II was completed on 12/13/24 and a new mental illness diagnosis was added in November 2025 so a new PASARR Level I assessment should have been completed. 2.The facility policy titled admission Criteria revised March 2019 documents all new admissions and readmissions are screened for Mental Disorders (MD), Intellectual disorders (ID) or related disorders (RD) per the Medicaid Preadmission Screening and Record Review (PASRR) process. R6's undated Face Sheet documents R6 admitted to the facility on [DATE]. R6's Electronic Medical Record (EMR) documents medical diagnoses as Psychotic Disorder with Hallucinations, Violent Behavior, Psychotic Disturbance, Mood disturbance, Anxiety, Depression and Major Depressive Disorder. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. R6's Electronic Medical Record (EMR) does not document a Level I or Level II Preadmission Screening and Resident Review (PASRR) being completed. R6's Interagency Certification of Screening Results dated 1/26/2024 documents R6's screening indicated supportive living services are appropriate. On 2/18/26 at 3:30 PM, V12 (Regional Clinical Nurse) stated the facility did request a Level I PASRR but the organization that completes all the facilities PASRR's withdrew the request. V12 stated the facility should have followed up to see why the PASRR testing date was withdrawn and obtained a Level I PASRR for R6 who probably has some disabilities.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review the facility failed to perform hand hygiene and sanitize a needleless access device prior to flushing a peripheral inserted central catheter for one of one resident (R53) reviewed for infection control on the sample list of 45 residents. Findings include: On 2/19/26 at 9:58 AM, a beeping noise was heard from R53's room. At that time, V2 (Director of Nursing) grabbed and applied gloves when entering the room. V2 did not wash or sanitize her hands before putting on the gloves. After entering the room, while wearing the same gloves, V2 pushed a button on R53's intravenous pump to stop the beeping. V2 then flushed R53's peripheral inserted central catheter (PICC) with a prefilled saline flush and then flushed the catheter with a heparin flush. V2 did not sanitize the needleless access device prior to flushing the PICC line. When finished, V2 removed the gloves and walked out of the room without sanitizing her hands. On 2/19/26 at 10:05 AM, V2 stated hand hygiene should be performed prior to putting on gloves. V2 also stated the needleless access device should be sanitized before flushing a PICC line with saline or heparin. The facility's Central Venous Catheter Care and Dressing Changes Policy dated 2001 documents a procedure to perform hand hygiene before applying gloves and to disinfect the needleless access device before flushing the PICC line.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review the facility failed to provide a minimum of 80 square feet of floor space per resident bed. This failure affects 33 residents (R2-R6, R8, R10, R13-R20, R22-R30, R32-R35, R37, R38, R40, R49 and R50) out of 45 residents in the sample list. Findings include: The facility daily Midnight Census Report dated 2/17/26 documents 33 residents (R2-R6, R8, R10, R13-R20, R22-R30, R32-R35, R37, R38, R40, R49 and R50) reside in the undersized rooms. Historical room size documentation and actual measurements demonstrate the facility's rooms 101 through 111, 201 through 210, and 301 through 311 do not provide 80 square feet per resident bed. Rooms 101 through 111 and 201 through 210 provide 73 square feet per resident bed, and rooms 301 through 311 provide 78 square feet per resident bed. On 2/19/26 at 7:10 AM, R35 and R29 both stated they are roommates. R35 and R29 both stated their room is too small. R29 stated it would be nice to have a larger room to have more room to move around. On 2/19/26 at 7:30 AM, R13 and R14 both stated they are roommates. R13 and R14 both stated they do not have enough room for their belongings. R13 stated both R13 and R14 'have a lot of stuff' that there is nowhere to put away. R13 stated We have to just stack our stuff up because there isn't any room for extra tables since the rooms are so small. On 2/17/26 at 11:00 AM, V1 (Administrator) stated the facility has rooms that are not regulatory size. V1 stated any of the residents could be housed in any of the rooms. V1 stated all of 100, 200 and 300 halls rooms are too small. V1 stated the 400 hall is typically reserved for short term residents but many times the 400 hall is empty because we like to keep everybody together on the same halls. On 2/18/26 at 2:00 PM, V12 (Regional Registered Nurse) stated the facility has always got the room size tag due to the facility has rooms that are too small.		