

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Monmouth Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 117 South I Street Monmouth, IL 61462	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31283</p> <p>Based on interview and record review, the facility failed to ensure an allegation of neglect was reported to the State Agency for one of three residents (R1) reviewed for neglect in the sample of three.</p> <p>Findings include:</p> <p>The facility's Abuse, Prevention and Prohibition Policy (reviewed 2021) documents the following: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of allegations of abuse or neglect or the Administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. If the event that caused the allegation do not involve abuse and do not result in serious bodily injury, these will be reported to the Administrator immediately and to State Survey Agency no later than 24 hours.</p> <p>On 05/20/24 at 01:17 PM, V1 (Administrator) stated that approximately one week ago, she received a call from V12 (Nurse at R1's Surgeon's office) vocalizing multiple concerns of neglect. V1 stated that V12 reported the following: R1 had been incontinent and was not wearing an incontinence brief and staff at the office had to provide incontinence care to R1 during his office visit; R1 had fallen multiple times; R1 was not sent to the office with a mechanical lift sling. V1 stated she conducted an investigation and interviewed the staff that accompanied R1 once they returned to the facility from his appointment.</p> <p>R1's Abuse Allegation Investigation (dated 05/15/24) documents the following: On 05/15/24 at approximately 01:30 PM, (V1) received a phone call from (V12, Nurse at local Surgeon's office). (V12) stated (R1) was, 'a mess the moment he left your building.' (V12) described that (R1) stated to her he had fallen twice that morning. He was not wearing an adult brief and we (facility) did not send him with a (mechanical lift) (transfer) sling. She stated (R1) had a wound on his coccyx that needed re-dressed due to him having a bowel movement, and medical office staff cleaned him up and put a brief on him with a pair of mesh underwear and were returning (R1's) shorts in a bag. This investigation does not document that the State Agency was initially notified of the allegation, or that a final notification was sent upon completion of the investigation.</p> <p>(continued on next page)</p>

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/21/24 at 02:00 PM, V1 (Administrator) confirmed that the State Agency was never notified of the allegation of neglect involving R1 on 05/15/24.</p>