STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146193	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Rochelle	2203 Flagg Road Rochelle, IL 61068

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 40085 Based on interview and record review the facility failed to ensure showers were provided for 5 of 8 residents (R1, R2, R3, R10, R11) reviewed for Activities of Daily Living (ADL's) in the sample of 11. The findings include: On 5/14/25 9:10 AM, R2 said, I am supposed to get two showers a week on Mondays and Thursdays and that doesn't always happen. Last Monday I asked about my shower and the CNA's (Certified Nursing Assistants) just looked at each other and didn't say a word. R2 said she keeps track of what happens at the facility by writing things down, so she has the correct days and times to reference to. On 5/14/25 at 8:36 AM, V4 (CNA) said when the facility is not staffed well enough there are times that they cannot get to residents to get the showers done. On 5/14/25 at 11:21 AM, V8 (CNA Coordinator) said residents should get showers twice a week. If a shower is missed or a resident refused, they should attempt again on the next shift or next day. V8 said if a shower is refused it should be documented in a shower sheet. On 5/14/25 at 1:54 PM, V10 (CNA) said the facility was very short staffed on Friday 5/9/25 and they were not able to do showers for 3 residents including R3, R10 and R11. V10 said that day they were not able to get to everyone on time to do incontinent cares or feeding due to having very low numbers of CNA's working. V10 said R10 had followed her asking about her shower and she felt so bad telling her that she could not do it because they were short staffed. On 5/14/25 at 2:03 PM, R10 said she was told last Friday that she couldn't get a shower because they didn't have enough staff. R10 said, I don't refuse showers we should get them twice a week. The facility provided shower schedule for the Liberty Lane wing shows that residents should receive showers twice a week. R1 should receive showers on Wednesday and Saturday, R2 should receive showers on Monday and Thursday and R3, R10 and R11 should receive showers on Tuesdays and Fridays. The facility provided showers sheets show that 2 showers were not done twice a week for R1 and R2. R1's shower sheets show he received showers on 4/18/25, 4/26/25, 4/30/25, 5/3/25, and 5/11/25. R2's shower sheets show she received showers/bed baths on 4/7/25, 4/14/25, 4/21/25, 4/24/25, 4/28/25, and 5/1/25 there are no documented showers/bed baths for her after 5/1/25. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 V2 (Director of Nursing) was asked for shower sheets for R3, R10 and R11 for 5/9/25 which was a schedules shower day for all of them. V2 said they did not have any shower sheets for those residents for that day. The facility provided Personal Care of Residents Policy revised 12/02 shows each resident shall have proper daily attention and care including as many baths and hair washes as necessary for hygiene needs.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45540 Based on interview, and record review the facility failed to provide supervision for a resident who was a fall risk, resulting in subsequent falls. This applies to 1 of 3 (R1) residents in the sample of 11 reviewed for falls. The findings include: R1's Resident Face Sheet printed on 5/14/2025 lists the resident as an [AGE] year-old male with medical diagnoses of unspecified dementia, severe, with anxiety and altered mental status admitted on [DATE]. On 5/14/2025 at 12:08PM, V3 Registered Nurse (RN) said she was working on 5/9/2025 with (R1). V3 said a family member came to get her to report a resident had fallen. V3 said (R1) was found in his room on the floor next to his bed. V3 said (R1) stated he was trying to go to the bathroom and had hit his head when he fell . V3 said he did have a small bump on the right side of his head. V3 said (R1) should not have been left in his room unsupervised because of his fall history. V3 said (R1) was sent out to the hospital and returned the same day and all tests were negative. V3 said they were short staffed that day and I'm sure that didn't help the situation. On 5/14/2025 at 12:17PM, V8 Certified Nursing Assistant (CNA) Scheduler said she was working on (R1's unit) on 5/9/2025 helping the two CNAs that were on the unit that day because there had been call-ins. V8 said they would normally have 3 or 4 CNAs on that unit and that day they had two, plus her helping. V8 said she got pulled away from the unit to help off the unit with something and when she came back (R1) had fallen. V8 said (R1) is a fall risk. On 5/14/2025 at 1:54PM, V10 CNA said we were short staffed on the 5/9/2025. V10 said (R1) should have been supervised and was not. V10 said we found him on the floor in his room. V10 said there were only 2 CNAs that day and we were putting people back to bed so (R1) was not supervised and should have been. 5/14/2025 at 1:26PM, V16 RN said on she was working on 5/11/2025 and was the nurse for (R1). V16 said (R1) had been restless that day and was to be kept in the common area. V16 said (R1) was wheeling himself around, stood up and fell . V16 said staff couldn't get to him before he fell . V16 said (R1) fell back and hit his head and there was some bleeding. V16 said (R1) was sent out to the hospital and returned the same day. V16 said the CT scan was negative, and they couldn't find any lacerations. V16 said (R1) did not get any stitches, glue and no fractures. V16 said he should be supervised. V16 said the unit only had 2 CNAs that day at the time of the fall which was around 6:35PM. V16 said 2 CNAs on that unit is not enough. R1's progress notes dated 5/9/2025 at 1:47PM, shows resident was noted on the floor next to the bed. Resident stated he was trying to get up and lost his balance and stated he hit his head. Physician contacted ok to send to emergency room for CT scan. Progress notes from 6:19PM states resident returned from the hospital no new orders and CT scan was negative. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated 2/14/2025 to 5/14/2025 shows, resident at risk for falling [related to] weakness from recent illness and new environment started on 2/12/2025. The facility provided All Falls for Facility document printed on 5/14/2025 shows falls for 5/11/2025 and 5/9/2025 for [R1].

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085 Based on interview and record review the facility failed to provide adequate staffing to meet the needs of the residents. This failure has the potential to affect all 76 residents residing in the facility. The findings include: The facility completed entrance form titled Facility Data Sheet and the Resident Roster shows the facility census on 5/14/25 was 76. On 5/14/25 at 8:36 AM, V4 CNA (Certified Nursing Assistant) said generally for the Liberty Lane unit which has 27 residents on it they have only 2-3 CNA's for the whole unit. V4 said the unit has a lot of heavy care residents including mechanical lifts. V4 said when staffing is low sometimes showers are missed, and residents have to wait longer because they have to prioritize who they get to first and can lay down. On 5/14/25 at 8:48 AM, V5 and V6 both CNA's said the Liberty Lane unit is a very heavy patient care unit of the facility and they are 13 residents requiring mechanical lifts on that unit. V6 said, When we have only two CNA's that is a big problem because two of us have to be in the room together when we are transferring residents into and out of bed to lay them down and do cares. There are also residents who need feeding assistance and if they are in helping other residents then there are simply not enough staff to get to everyone. V5 said they have to prioritize who gets changed going off from who was last changed. V6 said residents families get upset with us about residents having to wait and we explain it to them why it is. Both said it is very often that the facility is running short of CNA's to care for the residents. V6 said residents should get changed every couple hours and receive showers twice a week and when there is not enough staff this doesn't happen. On 5/14/25 at 9:10 AM, R2 said, I have never been so unhappy in my entire life. I came here after another facility I was at closed down. I wait a long time when I put my call light on. Last evening I put my light on to talk to a nurse at 4 PM and I am still waiting today for that nurse to come. Last Monday I didn't get my shower/bath I asked the CNA's about it and they both looked at each other and didn't say a word. While interviewing R2 she pulled out packets of paper to show this surveyor where she documents everything that happens during the day. R2 had documented that she was last checked or changed at 5:15 AM today and prior to that it was 9:30 PM last evening. R2 said she waits long periods for call lights to be answered, 30 minutes or more, and she can tell when the facility is short staffed which is most days. R2 said she refrains from making a big fuss about the lack of care and staffing at the facility because she feels like she gets dismissed as a [AGE] year old senile resident. R2 said, I have my wits about me. I know what is going on around me. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/14/25 at 11:21 AM, V8 (CNA Scheduler) and V2 (Director of Nursing) said staffing is a challenge at the facility especially when there are call ins. V8 went over the recommended staffing numbers which she said is census and not acuity based. There are 4 sections to staff, the Bounce Back wing A and B, Liberty Lane and Memory Lane. V8 said they recommended staffing is 4 CNA's and 2 nurses on Bounce Back for days and evenings and on nights 2 CNA's and 1 Nurse. Liberty Lane staffing is for 1 nurse, and they try to get 3 CNA's but prefer 4 CNA's on days and evenings and 2 CNA's and 1 nurse for night shift. V2 said, We have been trying to have 4 CNA's on each side on days and evenings. On Memory Lane there is 1 nurse and 2-3 CNA's, on days and evenings and a nurse floats over to Memory Lane for med pass on night shift and there are 2 CNA's. V2 said they do hear complaints that there is not enough staff at the facility. V2 said it is company policy that residents get two showers a week. V8 said on 5/9/25 day shift there was numerous call ins, and the facility was short staffed. V2 said she was the only CNA with the 2 nurses for a couple hours on the Bounce Back wings, and the Liberty Lane had only 2 CNA's and a nurse who was training a new staff nurse. V8 said it can be difficult to get everything done on time when there are only 2 CNA's on a unit especially on Liberty Lane because it is a heavier care hallway with lots of residents needing to be transferred via mechanical lifts. V8 said if the staff cannot get to showers, they should offer them on the next shift or the next day. 2 weeks of master staffing schedules showing call ins and the actual staff who worked, from 4/30/25-5/14/25 were reviewed. The schedules show on the following dates the facility did not have the facility recommended number of CNA's to provide care to the residents: 5/1/25, 5/3/25, 5/5/25, 5/9/25, 5/10/25, 5/11/25. On 5/14/2025 at 12:08PM, V3 Registered Nurse (RN) said she was working on 5/9/2025 with (R1). V3 said a family member came to get her to report a resident had fallen. V3 said (R1) was found in his room on the floor next to his bed. V3 said (R1) stated he was trying to go to the bathroom and had hit his head when he fell . V3 said (R1) should not have been left in his room unsupervised because of his fall history. V3 said (R1) was sent out to the hospital and returned the same day and all tests were negative. V3 said they were short staffed that day and I'm sure that didn't help the situation. On 5/14/25 at 1:54 PM, V10 CNA said it happens all the time that the facility is short staffed, and they have told administration many times that they need more help. V10 said on 5/9/25 they were so short staffed that 3 residents (R3, R11 and R12) did not get showers done. V10 said they were not able to get the residents toileted or incontinence care done on a timely basis and the meal trays sat for a long period of time before they were able to pass them because every unit was short staffed. V10 said there was also a fall (R1) had been left in his room unsupervised after therapy and he is someone who is supposed to be observed. V10 said her and another CNA were in resident rooms in the afternoon putting people to bed and could not supervise R1 and the next thing she knew he had fallen and was lying on the floor of his room. A facility provided fall log shows R1 had falls on the following dates, 3/18/25, 4/3/25, 4/19/25, 4/26/25, 4/30/25, 5/9/25, and 5/11/25. On 5/15/25 at 2:03 PM, R10 said it happens a lot that she waits 40-45 mins for her call light to be answered, and she was told last Friday 5/9/25 that she couldn't get a shower because they didn't have enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility provided showers sheets show that 2 showers were not done a week for R1 and R2. R1's shower sheets show he received showers on 4/18/25, 4/26/25, 4/30/25, 5/3/25, and 5/11/25. R2's shower sheets show she received showers/bed baths on 4/7/25, 4/14/25, 4/21/25, 4/24/25, 4/28/25, and 5/1/25 there are no documented showers/bed baths for her after 5/1/25. On 5/14/25 V2 (Director of Nursing) was asked for shower sheets for R3, R10 and R11 for 5/9/25 which was a scheduled shower day for all them. V2 said they did not have any shower sheets for those residents for that day. The facility provided Staffing policy revised on 9/18 shows staffing should be based on number, acuity and diagnosis and the facility should ensure adequate staffing will be met to provide resident care.