STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 7/9/24-IL176734	S 000		
S9999	Final Observations Statment of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and record review the facility failed to use the appropriate size shower chair for	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

1 (R1) of 4 residents reviewed for accidents in the sample of 4. This failure resulted in R1 sliding down in the chair into the open part, causing an acute impacted fracture of the left femoral neck. This past non-compliance occurred between 07/10/2024 and 07/16/2024.

The findings include:

R1 ' s Resident Face Sheet documents an initial admission date to the facility of 05/07/2022 with diagnoses including unspecified dementia, anorexia, hypokalemia, chronic obstructive pulmonary disease, anxiety, major depressive disorder, arthritis, restlessness, agitation, and pseudobulbar affect. Additional diagnoses include acute impacted fracture of the left femoral neck dated 07/10/2024.

R1 ' s MDS (Minimum Data Set) section C, dated 06/21/2024, documents that R1 has a BIMS (Brief Interview of Mental Status) of 05 indicating R1 has severe cognitive impairment. The same MDS section GG documents that R1 has impairment in both sides of lower extremities (hip, knee, ankle, foot) and uses a wheelchair as a mobility device. The same section, GG0130 documented Shower/bathe self: as a 01 indicating R1 is dependent for care (helper does all of the effort). Section GG0170 documented Tub/Shower transfer as a 01 indicating R1 was dependent for transfers (helper does all of the effort). R1's electronic medical record vital sign tab documented R1 has a height of 5 foot 2 inches and a July 2024 weight of 110 pounds.

R1 ' s Care Plan with a date of 01/17/2024 documented a focus area of "I am cognitively impaired due to disease progression of Dementia. I demonstrate poor short- and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

long-term memory, disorganized thought process, delayed processing, inability problem solves, and impaired safety awareness. My appetite is poor. I require verbal cues and substantial to dependent staff assistance for ADL ' s (Activities of Daily Living) and mobility. I am usually able to answer yes/no questions appropriately with a goal of "Will remain safe. " Documented interventions include verbal cues as needed, simple yes/no questions and commands and observe whereabouts - encourage to stay in common areas when out of room for staff supervision.

Undated facility final investigation report for R1 documents in part, "On 7/9/24 ...It was noted that resident had a bruise to posterior left upper left." An Xray was ordered and completed on 7/10/24. "7/10/24 2 view left femur Xray result: acute impacted left femoral neck/intertrochanteric fracture ... Following facility investigation this resident had slid through the opening of the shower chair and required 2 assist out of the opening. She had a bruise that was observed on the back of her leg following shower under the fractured hip. Staff education was initiated to give showers in appropriate fitting shower chair."

R1 ' s progress note, authored by V10 (Licensed Practical Nurse/LPN) dated 07/08/2024 with a time of 2:21 p.m., documented CNA (Certified Nursing Assistant) alerted this nurse that resident has a bruise on the back of her left leg above her knee. Resident is not complaining of any pain at this time. The bruise is black-purplish color, it is 8cm (centimeter) x 5cm. CNA and this nurse believes that the bruise came from when night shift got her up this morning, they put the bed rail down and when they set her up on the side of the bed the back of her leg hit the side rail. We replaced the hard side rail with a soft side rail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

POA (Power of Attorney) and V4 (Nurse Practitioner) notified.

R1 ' s progress note, authored by V11 (Registered Nurse/RN) dated 07/09/2024 with a time of 7:30 A.M., documented CNA notified this nurse that resident has a large purple bruise on inside of left thigh that goes from groin to knee. Resident is crying and complaining of pain. This nurse will notify V4 this am when she comes to this facility to make rounds.

R1 ' s progress note dated 07/09/2024 authored by V11 (RN) with a time of 8:30 A.M. documented V4 here making rounds. This nurse informed her of the bruising to resident's inner left thigh. V4 stated that she was aware of the bruising to posterior left knee, as it had been reported yesterday. V4 said she would look at it when she saw the resident.

R1 ' s progress note dated 07/09/2024 authored by V11 with a time of 10:30 A.M. documented Received order from V4 to obtain x-ray of L (left) hip, pelvis, and L femur related to bruising and pain.

R1 ' s progress note dated 07/10/2024 authored by V12 (RN) with a time of 2:12 P.M., documented X-ray obtained this afternoon of resident's Lt (left) femur/pelvis. Results from X-ray reveal acute impacted left femoral neck/intertrochanteric fracture. V4 notified, resident to be sent to local hospital ER (Emergency Room). POA notified of break and of resident going to ER. Local Ambulance company in facility to transfer resident.

R1 ' s progress note dated 07/10/2024 authored by V2 (RN/Director of Nursing) with a time of 6:29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

P.M. documented Resident is admitted to hospital. Room number not available at this time. Dx (diagnosis): left hip fracture.

R1's X-ray report with a date of 07/10/2024 documented the procedure as Left hip, unilateral w/Pelvis. Results are as follows: as an acute impacted fracture of the left femoral neck. There is a 3mm (millimeter) offset of fracture fragments and impaction of the fracture site. There is multiple screws involving proximal right femur.

On 08/22/2024 at 10:34 AM, V5 (LPN/Minimum Data Set/Care Plan Coordinator) stated she was working the floor on the Saturday that R1 received her shower. V5 stated she was walking up the hall and noticed the call light was on in the shower room. V5 stated she entered the shower room and saw R1 in the shower chair and two staff providing care. V3 and V9 stated they did not need anything so V5 went out of the shower room to continue doing what she was. V5 stated that R1 was not straight in the shower chair but the shower chair wasn't positioned straight with R1. V5 stated that later that week when she was at work, she heard V2 talking about R1 having a bruise and that they were investigating it. V5 stated the next day it was discussed that the bruise was worse, so she went to talk to V2 about it. V5 told V2 that staff were giving R1 a shower in a bariatric chair and the chair was way too big for R1. V5 stated that she told V2 that R1's positioning in the chair was off. V5 stated that when she entered the shower room, R1 was not in any distress and the staff did not look like there were any problems which is why she left the shower room. V5 stated that R1 was very impulsive at times and had cognitive issues.

On 08/21/2024 at 3:34 PM, V2 (RN/Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

Nursing) stated that she was not aware of any incident with R1. V2 stated it was reported to V10 (LPN) from a CNA that R1 had a bruise to the back of her left leg. The following day the bruise was worse. V4 (Nurse Practitioner) was in the facility and saw R1. V4 ordered x-rays on R1. The x-rays came back with a fracture. V2 stated that she immediately started investigating the cause. V2 stated at first, they were looking for a transfer that did not go how it should or a fall that was not reported. V2 stated she interviewed staff about R1 having a fall, if they knew how R1 obtained the bruise, and if any staff had been a part of or witnessed an unsafe transfer. V2 stated that R1 would often throw her legs over the side of her wheelchair and did ask staff if they had ever seen R1 have any body part stuck in the side rail. V2 stated that when she was interviewing V5, V5 told her to look into the shower that R1 was given on 07/04/2024. V5 told V2 that when she went into the shower room to answer the call light, R1 did not look right in the shower chair and the V9 reported that she had slid down multiple times during the shower. V2 stated she looked at the shower chair that staff had used on R1 on 07/04/2024 because it was reported to V2 by V5 that the shower chair was too big. V2 stated V9 had used a bariatric shower to give R1 a shower. V2 stated that R1 was a little resident, and the shower chair was too big for her. V2 stated that after review of shower chair and bruises, that the bruise lined up with the front area of the shower chair that was open. V2 stated that during the investigation staff reported that R1 was difficult to give a shower to as she would constantly move and slid around in the shower chair. V2 stated that R1 had sun downing and her behaviors were worse in the afternoon.

On 08/21/2024 at 4:14 PM, V1 (Administrator)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

stated that R1 had bruising that staff noticed. V1 stated that V2 investigated the cause of the bruising. V1 stated that R1 had more pain and V4 ordered x-rays. V1 stated that the x-ray results came back with a fracture. V1 stated that staff were having difficulty keeping R1 in the shower chair to complete her shower. R1 was noted to be sliding down and having to be repositioned. V1 stated that R1 did not have any falls or prior injuries that she is aware of. V1 stated that the R1 was sent to a local hospital for evaluation of the fracture. R1 went to another facility after the hospitalization. V1 stated that R1 did not have full range of motion and was constantly having to be repositioned in her wheelchair prior to this incident. V1 stated that she always leaned to one side and had a kyphotic posture. V1 stated that the facility reviewed shower chairs and what size resident best fit each one. The facility then ordered a pediatric chair for smaller sized residents. V1 stated the facility did education regarding the shower chairs and have color coated the shower schedule to alert staff of what chair to use for each resident. V1 stated that V2 has completed audits regarding shower chair use.

On 08/22/2024 at 8:23 AM, V3 (CNA) stated she was not the CNA giving the shower the day in question. V3 stated she helped transfer R1 to the shower chair and told V9 to use the call light when she needed help transferring R1 back to her chair. V3 stated that she saw the call light on and went back into the shower room. V9 told V3 that R1 had tried to jump out of the shower chair. V3 stated she helped transfer R1 and then left the room to go provide care for other residents. V3 stated that R1 was hard to shower because she would constantly be sliding down in the chair. V3 stated she is not aware of R1 ever having a fall in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

On 08/22/2024 at 9:22 AM, V4 (Nurse Practitioner) stated she did provide care for R1. V4 stated that she had seen R1 on 06/13/2024 and 07/03/2024 prior to seeing her on 07/09/2024. V4 stated on the prior visit she was complaining of pain and was noted to have an abscessed tooth. V4 stated on 07/09/2024 R1 was saying it hurt but could not specify what exactly hurt. V4 stated since there was bruising, she ordered x-rays to be completed. V4 stated that R1 had a bone density test in 2018 that had documented borderline osteopenia. V4 stated that before R1 was admitted she had had numerous falls at home but was not aware of R1 having any falls in the facility.

Attempts were made to contact V9 (CNA) via phone on 08/22/2024 at 11:48 A.M. and 2:05 P.M.

A handwritten statement that was included with the investigation titled "Regarding R1 " documents, V9 (CNA) documented she did not see R1 sitting on her foot pedals, and she did not feel the shower chair was the appropriate size for R1. V9 ' s written statement documented, "Gave shower on the 4th of July, V3 assisted me in transferring her to and from the shower. I did not observe a bruise on her thigh at the time of shower or after. Her butt slides forward and you have to pick her up and straighten her up. She was very agitated. Kept saying she was going to jump in the floor. So, I stood in front of her while drying her off. She tried to scoot herself forward out of the chair multiple times after that. I just held on to her and hit the call light for assist. "

Document titled "Local Hospital R1 Progress Note "dated 07/13/2024 documented R1 had a left intertrochanteric femur fracture with no plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 for surgery at this time. On 08/21/2022, V1 provided their QAPI (Quality Assurance Performance Improvement) Ad Hoc Form from at QAPI meeting on 7/10/24 outlining the actions taken by the facility prior to the survey date to correct the noncompliance. Prior to the survey date, the facility took the following actions to correct the non-compliance: Immediate Corrective Action for those affected by the deficient practice: Sent R1 to ER for further evaluation and treatment. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents could be affected. Measures put into place/systemic changes to ensure the deficient practice does not recur: Staff education on using proper fitting wheelchairs for small residents. Completed on 07/16/2024. Shower sheets coded for residents who should use small / pediatric shower chair (who weigh under 120 pounds) Completed 07/16/2024. Verbal / written warning for CNA who completed the shower. Completed 07/11/2024. Plan to monitor performance to ensure solutions are sustained: Code new admits (under 120 pounds) on shower sheets upon admission. Audit 2 times weekly x 4 weeks, staff are using correct / appropriate fitting chair. (A)	S9999		