STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY MANOR	**2345 NORTH SEMINARY STREET , GALESBURG, Illinois, 61401**

(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) COMPLETION DATE
S0000	Initial Comments FRI of 9/9/25/2616285	S0000		
S9999	Final Observations Statement of Licensure Violatiations Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide staff supervision during toileting for a resident that was assessed as requiring toileting assistance (R2), one of three residents reviewed for falls, in a sample of 3. This failure resulted in R2 being left unsupervised, falling from a toilet resulting in a head laceration, extensive bruising and fractured ribs. FINDINGS INCLUDE: R2's facility Resident Face Sheet documents that R2 was admitted to the facility on 07/17/2025 with the following diagnoses: History of Falls, Displaced Fracture of Greater Trochanter of Left Femur, Need for Assistance with Personal Care, Weakness, Generalized Anxiety Disorder, Exudative Age-Related Macular Degeneration, right eye, Osteoarthritis, Asthma and Chronic systolic (congestive) heart failure. R2's Hospital History and Physical Transfer Notes document, "(R2) has a past medical history significant for congestive heart failure (CHF), a fall, hypertension (HTN), hyperlipidemia, atrial fibrillation (a-fib), urinary incontinence, takotsubo syndrome, macular degeneration, and a history of an anterior wall myocardial infarction (MI) resulting in weakness. The patient fell and sustained a left femur fracture, for which an open reduction and internal fixation (ORIF) procedure was performed. (R2) admitted to Skilled Nursing Facility on 07/17/2025 for skilled nursing and rehab. (R2) asked to be seen by primary team to optimize therapy, pain control and discharge planning. (R2)'s plan and progress were discussed with nursing staff and therapy. Frequent monitoring and management by trained clinicians are essential to safeguard patient well-being, enhance recovery, and prevent clinical decline. The complexities of rehabilitation, chronic conditions, and individualized treatment plans necessitate regular assessments for early detection of complications, frequent adjustments of treatment plans and to promote patient safety. R2 becomes very anxious and starts to panic making her very unsafe at times." R2's Care Plan, dated 7/18/25 includes the following Problem Areas: (R2) is at risk for falling related to recent illness/hospitalization and new environment. (R2) has increased confusion and does attempt to get up (as desired) without using call light, despite numerous	S9999		

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S9999	Continued from page 2 education attempts. (R2) has voiced to staff that she does not like to turn her call light on because she doesn't want to bother anyone. (R2) needs encouragement to utilize staff for help." R2's Fall Risk Assessment Tool, dated 7/18/25 documents, "(R2) has a history of falls, is incontinent of bowel and bladder, receives opiates, diuretics, hypnotics, sedatives and psychotropic medication and requires assistance for mobility, transfers or ambulation. Score is 17: High Risk for Falls." R2's Occupational Therapy Screen, dated 7/18/25 documents, "Toileting hygiene = Substantial/maximal assistance." R2's Minimum Data Set Assessment, dated 7/24/25 documents: Section GG: Toileting Hygiene/Admission Performance - The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment: 02-Substantial/Maximal Assistance and Toilet Transfer/Admission Performance - The ability to get on and off a toilet or commode: 01-Dependent." R2's Physician Progress Notes, dated 7/21/25 document, "(R2) fell walking down some steps (and) did sustain a fracture of the left hip. (R2) is Non weight bearing and is Non ambulatory at this time. Diagnosis: Closed Fracture of Left Hip." R2's Nursing Progress Notes, dated 9/09/2025 at 10:19 A.M. document, "This nurse was standing outside (R2's) room when a loud noise was heard and (R2) started to yell. This nurse entered the room and (R2) was noted to be laying on the bathroom floor with gait belt around waist. (R2) had her walker under her legs. (R2) was laying on her back. (R2) had a gash to bridge of her nose, her glasses were in place. (R2) had a laceration to her forehead and to her right upper arm. Cold compresses were applied to (R2's) forehead and to bridge of nose to help stop the bleeding. (R2) was (complaining) of leg pain. (R2's) right leg did have external rotation noted. (R2) denied any head or neck pain. Blanket was placed under her head. 911 was called for transport to Emergency Room. Emergency Medical Transport placed a sling under (R2) and manually lifted (R2) onto the stretcher. (R2) was alert and orientated and talking with staff the entire time." R2's Nursing Progress Notes, dated 9/09/2025 at 1:33 P.M. document," (R2) being admitted to hospital for multiple broken ribs at this time."	S9999		

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S9999	Continued from page 3 R2's (Hospital) Admission History and Physical, dated 9/9/25 documents, "(R2) arrived at the emergency room from (the facility). (R2) was sitting on (the) toilet when she lost her balance and fell onto the floor. In this fall, (R2) suffered a laceration to her right forehead. (R2) has some skin tears to her left knuckle and right elbow. There is an abrasion to her chin. There is some bruising and swelling over her right clavicle and an abrasion and bruising on her nose. (Computerized Tomography/CT) of (R2's) head showed soft tissue thickening consistent with contusion of the scalp. CT of (R2's) facial bones showed contusions and hematomas. CT Angiogram of (R2's) chest showed right supraclavicular contusion and hematoma and nondisplaced fractures of the posterior left 8th and 9th ribs." R2's (facility) Nursing Progress Notes, dated 9/16/25 document that R2 was returned from the hospital. On 9/17/25 at 10:05 A.M., R2 was up in a wheelchair in her room. R2 was alert and able to answer questions appropriately. Extensive bruising was present no to (R2's) entire face, neck, hairline and visible arms and legs. A healing laceration was present to (R2's) right front forehead. At that time R2 stated, 'I'm in so much pain. They left me in the bathroom. They weren't supposed to, and I fell and broke my ribs. I can't hardly move anymore." On 9/17/25 at 11:07 A.M., V6/Certified Nursing Assistant (CNA) stated she was the CNA the day that (R2) fell. V6/CNA stated that R2 had been (in the facility) for a couple of months and we were trying to get (R2) to do more for herself. V6/CNA stated that (R2) had been in therapy and she thought R2 she was getting stronger. V6/CNA stated she walked R2 from just outside of her bathroom, with a gait belt and set her on the toilet and left. V6/CNA stated she walked down the hall to (another hall) and was standing there charting. V6/CNA stated she heard a yell and when she got to (R2's) room that (V3/Licensed Practical Nurse) was already in the room. V6/CNA stated that (R2) was bleeding pretty bad and was complaining of a lot of pain. V6/CNA stated she usually stayed with (R2) when she was in the bathroom, or stood right outside of the bathroom door, with the door cracked. V6/CNA stated (R2) had been in therapy and gotten so much stronger, I thought (R2) would be okay if I walked away." On 9/17/25 at 2:33 P.M., V2/Director of Nurses verified that R2 required extensive staff assistance for toileting, was very anxious and required frequent staff encouragement to use the call light for staff	S9999		

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S9999	Continued from page 4 assistance. At that time V2/Director of Nurses stated that since R2's recent fall from the toilet, upon return to the facility, staff had updated her care plan to include not leaving R2 alone on the toilet. (B)	S9999		