

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2025
NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE-SILVIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 TENTH ST SILVIS, IL 61282		
(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
A 000	Initial Comment Facility Reported Incident IL195906. VIOLATION 295.6000a)13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; VIOLATION Based on record review and interviews, the establishment neglected to properly assess and provide timely care for one of three sampled residents that sustained falls with injury. (R1) Findings include: R1's service plan notes that R1 was admitted to the Assisted Living side of the establishment on 1/4/22 with Diagnosis including but not limited to Degenerative Joint Disease, Hypertension, and Diverticulitis. Service plan notes that R1 was at risk for falls but was independent with ambulation.	A6000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A6000	Continued From page 1 R1's incident report dated 6/19/25 at 11:20 P.M., notes that R1 reported to E4 (Caregiver) that she had fallen and put herself back to bed. Report notes that R1 complained that she was experiencing pain in her right arm and right leg. E4 called on-call nurse (E2 Wellness Director) and took R1's vitals. On 7/15/25 at 12:28 P.M., E4 stated that R1 had pressed her call light around 11:30 P.M. on 6/19/25. R1 had informed her that she had fallen and gotten herself back into bed. R1 complained of right arm and right leg pain. E4 stated that there is not a nurse in the building during third shift so they are to call the on-call nurse to inform of the incident. E4 said that she called E2 to let her know R1 had fallen. E4 stated that E2 gave her instructions to take R1's vitals and nothing more. E4 stated that R1 pressed her call light several times between 11:30 P.M. and 6:00 A.M. complaining of right arm and right leg pain. E4 stated that she did not call E2 again the entire night but told day shift staff coming on at 6:00 A.M., what had happened. On 7/16/25 at 11:02 A.M., E2 stated that she did receive a call from E4 on the evening of 6/19/25 around 11:30 P.M.. E4 informed E2 that R1 had called E4 to her room stating that she had fallen and gotten herself back to bed. E4 told E2 that R1 complained of arm and leg pain. E2 stated that she instructed E4 to take R1's vitals. E2 stated that this was the only call that E4 had made to E2 that night. E2 stated that if E4 would have called E2 and informed her that R1 was continuing to complain of arm and leg pain, E2 would have instructed E4 to send R1 to the hospital for an evaluation and treatment. On 7/16/25 at 10:25 A.M., E3 (LPN) stated that	A6000		

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A6000	Continued From page 2 she had came on duty the next morning (6/20/25) at 7:00 A.M.. At around 7:30 A.M., her caregiver informed her that R1 was a little confused and in pain. E3 stated that she went to R1's room and assessed R1. E3 stated that R1's O2 Sats were low and she was having right arm and right leg pain. E3 stated that she called R1's daughter and R1's daughter came in to see R1. E3 stated that R1's daughter agreed to have R1 sent to the hospital at that time for an evaluation. (Around 9:00 A.M.) E3 confirmed that the facility does not staff third shift with a licensed nurse, so R1 had lied in bed in pain from 11:30 P.M. until 7:30 A.M. without being professionally assessed by a Licensed Nurse. R1's progress note confirms that E3 took R1's vitals on the morning of 6/20/25 and R1's O2 Sats were 77% and R1 was complaining of pain. R1 was sent to the hospital a little after 9:00 A.M.. Progress note notes that at the hospital R1 was found to have suffered a fracture of her right humerus and right femur.	A6000		