STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Grove Living and Rehab	502 North State Street Franklin Grove, IL 61031

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were in place for four of four residents (R1-R4) reviewed for safety/supervision in the sample of four. The findings include:1. R1's Face Sheet shows he was admitted to the facility on [DATE] with diagnoses including encephalopathy, diabetes, nicotine dependence, cardiomegaly, and history of falling.V1 (Administrator) stated that R1 did not have a Care Plan as he discharged from the facility the same day he was admitted .R1's Fall Scale dated January 24, 2026 shows he was a moderate risk for falling.R1's Nurses Notes dated January 24, 2026 at 4:42 PM shows R1 was admitted to the facility. R1 was transferred to the bed and family was at the bedside. R1 had a scab on his right knee with numerous bruises to both of his lower extremities. R1's Nurses Notes dated January 24, 2026 at 8:16 PM, entered by V3 (Licensed Practical Nurse/LPN) shows R1 was found on the floor face down with his head near the head of the bed and his feet towards his dresser. R1 had a medium sized pool of blood on the floor in front of him. R1 was noted to be incontinent in bed prior to the fall. R1 did not have any clothes on other than socks. R1 initially told staff he fell reaching for food that had fallen on the floor and hit his head first. When the emergency medical personnel arrived, R1 told them he woke up when he hit the floor. Injuries were noted to his right eyebrow, nose, and right knee abrasion re-opened. R1 was transferred to the local emergency room for evaluation.On February 1, 2026 at 5:15 PM, V8 (R1's son) said the day his father fell, V8's sister and brother-in-law were with R1 for about 2.5 hours before they went home. V8 said facility staff left R1 sitting at the side of the bed. V8 said R1 received steri strips to his eyebrow. V8 said R1 went to a different rehab facility after he left the hospital.On February 2, 2026 at 1:20 PM, V6 (CNA) said she saw that R1's call light was on, so she went into his room. V6 said R1 was on the floor next to his bed face down. V6 said R1 did not have any clothes on. V6 said there was blood on R1's knee and his face. On February 2, 2026 at 1:35 PM, V3 (LPN) said R1 was sitting on the side of the bed eating supper. V3 said she did not love the idea of him sitting on the side of the bed since he was a new admission and the staff did not know if R1 would try and transfer himself. V3 said residents use a mechanical lift until therapy can evaluate them. V3 said staff could have used a mechanical lift to put R1 in a chair. V3 said R1 had a history of falling. V3 said when R1 fell, he had a laceration to his eyebrow and reopen the laceration to his knee. V3 said R1 stated his head hurt where he cut it opened. V3 said R1 was naked when he was on the floor. On February 2, 2026 at 2:05 PM, V4 (Certified Nursing Assistant/CNA) said her and V5 (CNA) went into R1's room because his call light was on. V4 said that R1 said he wanted to sit on the side of the bed. V4 said the R1's family was at his bedside. V4 and V5 asked R1's family to let them know when family left. V4 said she let V3 (LPN) know that R1 wanted to sit on the side of the bed. V4 said R1's family did not let staff know when they left. V4 said that R1 was on the floor face down. V4 said R1 told her he was trying to pick food up off of the floor. V4 said she (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Franklin Grove Living and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 502 North State Street Franklin Grove, IL 61031	

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not get report on R1 when she came in for her shift. V4 said she was just told there was a new resident. On February 2, 2026 at 2:56 PM, V7 (Assistant Director of Nursing/ADON) said fall prevention interventions include opened doors, call light within reach, appropriate footwear, and side rails. V7 said residents are transferred using a mechanical lift until therapy can evaluate them. V7 said R1 was placed on a certain hall because there was higher traffic there so there was more supervision. V7 said there were two visitors with R1. V7 said V3 (LPN) called her and said R1 had been found on the floor and was sent to the hospital because he was on a blood thinner and there was blood on the floor. V7 said she let staff know when R1 was admitted , that R1 was a fall risk. V7 said she does not know how R1 fell out of bed. V7 said she assumed R1 was laying down in bed and may have rolled out. On February 2, 2026 at 3:21 PM, V5 (CNA) said R1 was at the facility when she arrived for her shift. V5 said she did not know how R1 transferred because therapy had not evaluated him yet. V5 said R1 was sitting on the side of the bed when she delivered R1's dinner tray. V5 said she tried to get R1 to lay in bed to eat, but R1 was insistent on sitting on the side of the bed. V5 said she educated R1 on the reason why she wanted him to lay down, so he did not fall. V5 said she let the nurse know that R1 was sitting on the side of the bed. V5 said family was at R1's bedside. V5 said she did not know that R1's family left, until she went into R1's room and he was on the floor. V5 said she prefers residents to lay in bed to eat, because it is safer. V5 said she was trying to prevent a fall. 2. R3's Face Sheet shows he was initially admitted to the facility on [DATE] with diagnoses including pneumonitis due to inhalation of food and vomit, sepsis, acute respiratory failure, anxiety disorder, restlessness and agitation, and bipolar disorder.R3's Fall Scale dated January 17, 2026 shows he has a high risk of falling.R3's Care Plan last revised on December 31, 2025 shows R3 is at risk for falls-ensure call light is within reach and encourage him to use it for assistance as needed.On February 2, 2026 at 9:37 AM, R3 was laying in his bed. R3's call light was on the floor at the foot of R3's bed. There were no floor mats in place to the side of R3's bed. There were floor mats folded up and against the windowpane next to R3's roommate's bed. On February 2, 2026 at 2:56 PM, V7 (ADON) said R3's fall prevention interventions include his call light in reach and floor mats on the floor. V7 said R3's call light is typically attached to his bed.The facility's Accident Incident logs shows that R3 had falls on December 27, 2025 and December 31, 2025. 3. R2's Face Sheet shows he was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, depression, anxiety disorder, history of falling, and restlessness and agitation. R2's Care Plan last revised on January 11, 2024 shows R2 is at risk for falls and ensure his call light is within reach and encourage him to use it for assistance. R2's Fall Scale dated December 1, 2025 shows R2 has a moderate risk of falling.On February 2, 2026 at 9:46 AM and 2:00 PM, R2 was laying in his bed on his left side. R2's call light was on his floor and out of reach at both times. 4. R4's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including dementia, depression, osteoporosis, anxiety disorder, difficulty in walking, and need for assistance with personal care. R4's Care Plan last revised on July 12, 2024 shows R4 is at risk for falls and ensure residents call light is within reach and encourage her to use it for assistance as needed. R4's Fall Scale dated December 17, 2025 shows she is a high risk for falling. On February 2, 2026 at 9:43 AM, R4 was laying in her bed. R4's call light was on the floor, not within R4's reach.The facility's Fall Prevention and Management Policy last reviewed on March 21, 2025 shows, Interventions will be implemented for residents, assessed by the admission nurse, determine to be at high risk at the time of admission for up to 72 hours. All staff must observed residents for safety.