STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145286	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Staunton Health and Rehab Ctr	215 West Pennsylvania Avenue Staunton, IL 62088

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise a resident's care plan with progressive interventions for 2 of 3 (R2, R5) residents investigated for falls in a sample of 25.Findings include:#1.R2's EMR Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE].R2's EMR dated 6/23/25 documents a diagnosis of Systemic Lupus Erythematosus, Unspecified; Epilepsy, unspecified, not intractable, without status epilepticus; and Altered Mental Status, unspecified.R2's MDS (Minimum Data Set) dated 11/28/25 documents a BIMS (Brief Interview for Mental Status) score of 9 out of 15. The MDS documents that the resident requires substantial/maximal assistance for roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer.R2's Care Plan Care Plan dated 7/1/25 documents (R2) is at risk for falls and injuries r/t daily use of anti-hypertensive medications, Narcotic use, and Cardiovascular medications. She is also noted to have tremors, which can impair her mobility and possibly contribute to falls. She has a history of falls with head injuries and displaced dens fracture.Interventions:5/2/25 - Bed in lowest position.5/2/25 - Ensure proper footwear when ambulating.5/2/25 - Instruct resident to avoid sudden position changes.5/2/25 - oriented to room.5/2/25 - provide adequate lighting.5/2/25 - provide/reinforce the importance of sitting on side of bed prior to standing.5/2/25 - Provide/Reinforce use of assistive devices: (specify: reacher, walker, cane, wheelchair, transfer pole, etc.)5/11/25 - (R2) is to have non-skid footwear on while in bed.7/11/25 - non-skid socks on while in bed.8/10/25 - Dycem placed in wheelchair.R2's F/U Occurrence Note dated 8/17/25 at 7:15 AM documents Incident Note: unwitnessed fall. CNA (Certified Nursing Aid) found (R2) on the floor @715. (R2) states she was not standing she was washing her face and tried to put her face towel on the dresser, but the wheelchair slid from under. I did a full head to toe assessment on (R2) with ROM (Range of Motion). She hit the right side of head and blood was on her hand, floor and towel. Denies any pain. V/S (Vital sign) (blood pressure) 115/75 P. (pulse)85 R. (respirations) 18 temp.(temperature) 97.6 O2. (oxygen saturations) 96%. Pt. (patient) A&O (alert and oriented) X 2. transferred to bed with two nurses and two CNA. pt stable. called 911. contacted POA. @740. Ambulance arrived @750. Contacted MD @751. Contacted DON (Director of Nursing) @ 752 left VM (voicemail).No care plan intervention noted for this fall.Facility Fall Investigation dated 8/17/25 at 7:15 AM documents fall, resident room, sitting. Fall caused by patient intent or behavior. Laying on ground. Resident just got up out of bed and was sitting the wheelchair. Assessment/Documentation, Fall Assessment Completed, Neuro checks initiated, routine safety checks, notified immediate supervisor, first aid initiated, Do not move, call bell in reach with instruction. Resident was sent to ED (Emergency Department) for further evaluation. Problem Statement: Resident attempting to get out of wheelchair. Root Cause: Resident attempting to get out of wheelchair. Investigative Statements: Nurse: unwitnessed fall. CNA found (R2) on the floor @ 7:15. (R2) states, she was not standing (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was washing her face and tried to put her face towel on the dresser but the wheelchair slid from under. I did a full head to toe assessment on [NAME] with ROM. She hit the right side of head and blood was on her hand, floor, and towel. Denies any pain. V/S 115/75 R 18 temp. 97.6 O2. 96% Pt. A&O X 2. Transferred to bed with two nurse and two CNA. Pt stable. Called 911. Resident: Resident stated she wasn't trying to get out of bed and walk, she was reaching over to put something away.R2's Health Status note dated 1/14/26 at 2:13 PM documents res (resident) leaning forward in w/c and fell forward out of chair, hit head on leg of STS (Sit to Stand), MD here and states to send to ER for Eval (Evaluation).No care plan intervention noted for this fall. Facility's Fall Investigation dated 1/14/26 at 3:00 PM documents Fall, resident room, sitting. Fall caused by patient intent or behavior. Resident went from chair to floor. No injuries noted. Assessment/Documentation, Fall Assessment completed, neuro checks initiated, notified immediate supervisor. Resident witnessed hit head and sent to ED per MD for further evaluation, education to staff to lay resident down immediately after meals. Problem Statement: Resident is A&O x 2, poor safety awareness, BIMS 9, intention of getting out of the w/c. Root Cause: Resident is A&O x 2, poor safety awareness, BIMS 9, intention of getting out of the w/c so she could get to bed. Investigative Statements: Nurse: res leaning forward in w/c and fell forward out of chair, hit head on leg of STS, MD here and states to send to ER for eval. Resident: resident stated she fell and that she wanted out of her chair. Witness: This nurse was walking past room and witnessed resident scooting to edge of wheelchair and pushed self out of chair and fell to floor hitting head on based of sit to stand. Resident was assessed and stated her head hurt. Floor nurse notified POA and MD. Resident to be sent to ED for further evaluation.#2.R5's EMR undated documents that the resident was admitted to the facility on [DATE].R5's EMR dated 8/22/25 documents a diagnosis of Parkinson's Disease without Dyskinesia, without mention of fluctuations, encounter for palliative care, and Malignant Neoplasm of Unspecified Renal Pelvis.R5's MDS dated [DATE] documents a BIMS score of 12 out of 15. The MDS documents that the resident is dependent for roll left and right, sit to lying, chair/bed to chair transfer, and tub/shower transfer. The MDS documents that the resident has an indwelling catheter.R5's Care Plan dated 8/26/25 documents [NAME] is at risk for falls and injuries r/t side effects of his psychotropic and opioid medication use. He is also at risk due to his diagnosis of Parkinson's disease and his involuntary movements. [NAME] has a history of falls. Due to his involuntary movements, [NAME] has been noted to slide out of bed. He currently has a low bed and double mattresses.Interventions:8/25/25 - bed in lowest position.8/25/25 - Encourage call light usage.8/25/25 - floor mat at bedside when in bed.8/25/25 - keep environment free from clutter.8/25/25 - Keep personal belongings within reach.8/25/25 - provide adequate lighting.10/23/25 - bolster on mattress. Hospice provided.11/10/25 - personal alarm on resident.R5's Health Status note dated 9/16/25 at 12:43 AM documents UPON MIDNIGHT Rounding Resident noted in his room, laying on the bathroom floor, on his Right side. Upon assessment (indwelling) Cath detached from Resident's Penis, a large amount of blood noted on the floor, and penis. Resident states he doesn't know where he was going or what he was trying to do at the time of Fall. Resident denies hitting his head. Resident states he is not so much in pain Resident's Bed was still in the lowest position and safety mat was in place. Resident was Mechanical lifted from the floor to his Bed. V/S: BP 128/82 HR 97 t 97.4F R 20 PERRLA (Pupils Equal Round Reactive to Light Accommodation), RESIDENT was a&o X2-3. 911 was called at 12:03AM, RES WIFE AND DAUGHTER NOTIFIED AT 12:04AM, MD NOTIFIED AT 12:05AM,EMS ARRIVED AT 12:15 AND RESIDENT WAS TRANSPORTED TO (Regional Hospital) AROUND 12:20AM.No care plan intervention noted for this fall.Facility's Fall Investigation dated 9/16/25 at 12:43 AM documents Found on floor. Laying on bathroom floor. No injuries noted. Assessment/Documentation. Care Plan updated. Neuro checks (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated. Notified immediate supervisor. Sent out for further evaluation, resident noted confusion with uti (Urinary tract Infection) on abt (Antibiotic). Problem Statement: Resident confused with poor safety awareness, and attempting to get out of bed without assistance. Root Cause: Resident confused, with poor safety awareness, and attempting to get out of bed without assistance. Investigative Statements: Nurse: Upon Midnight rounding Resident noted in his room, laying on the bathroom floor, on his right side. Upon assessment Foley Cath. Detached from Resident's penis, a large amount of blood noted on the floor, and penis. Resident states he doesn't know where he was going or what he was trying to do at the time of fall. Resident denies hitting his head. Resident states he is not so much in pain. Resident's bed was still in the lowest position and safety mat was in place. Resident was mechanical lifted from the floor to his bed. V/S: BP 128/82 HR 97 t 97.4F R 20 PERRLA, Resident was a&o x 2-3. 911 called at 12:03AM, Res. wife and daughter([NAME]) notified at 12:04AM, MD notified at 12:05AM, EMS arrived at 12:15 and resident was transported to (Regional Hospital)12:20am.R5's F/U Occurrence Note dated 12/30/25 at 2:00 AM documents Incident Note: Observed lying on floor next to bed and window, on floor mat lying on stomach with arms at side and legs extended. Slow response made eye contact but no verbal response. Moving extremities, no shortening or rotation of legs noted. Transferred from floor to bed via full mechanical lift and 3 assist. More responsive but slow, mumbling speech. Small red area to left cheek bone. Neuro checks initiated. (Indwelling) catheter patent draining dark yellow urine. Call light within reach. Hospice care.No care plan intervention noted for this fall.Facility's Fall Investigation dated 12/30/25 at 2:00 AM documents Fall, Resident room, in bed. Found on floor. On floor mat on stomach. No injuries noted.On 1/23/26 at 3:00 PM, V2, DON stated that some of the falls happened before she was hired. She stated that Care Plan Coordinator is new and learning.Facility's Accidents & Incidents policy dated 7/1/23 documents To provide staff with guidelines for investigating, reporting, and recording Accidents and Incidents. 4. Investigated and Follow up Action: A. The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties. E. The D.O.N, IDT (Interdisciplinary Team), and /or Designee will conduct an investigation of the accident/incident as well. Findings will be indicated in the appropriate area. The IDT will review within 24 hour or next business day and discuss and attempt to find out root cause and implement an appropriate intervention to attempt to prevent further falls.

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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** Based on interview and record review the facility failed to provide progressive interventions to prevent falls for 2 of 3 (R2, R5) residents investigated for falls in a sample of 25.Findings include:#1.R2's EMR Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE].R2's EMR dated 6/23/25 documents a diagnosis of Systemic Lupus Erythematosus, Unspecified; Epilepsy, unspecified, not intractable, without status epilepticus; and Altered Mental Status, unspecified.R2's MDS (Minimum Data Set) dated 11/28/25 documents a BIMS (Brief Interview for Mental Status) score of 9 out of 15. The MDS documents that the resident requires substantial/maximal assistance for roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer.R2's Care Plan Care Plan dated 7/1/25 documents (R2) is at risk for falls and injuries r/t daily use of anti-hypertensive medications, Narcotic use, and Cardiovascular medications. She is also noted to have tremors, which can impair her mobility and possibly contribute to falls. She has a history of falls with head injuries and displaced dens fracture.Interventions:5/2/25 - Bed in lowest position.5/2/25 - Ensure proper footwear when ambulating.5/2/25 - Instruct resident to avoid sudden position changes.5/2/25 - oriented to room.5/2/25 - provide adequate lighting.5/2/25 - provide/reinforce the importance of sitting on side of bed prior to standing.5/2/25 - Provide/Reinforce use of assistive devices: (specify: reacher, walker, cane, wheelchair, transfer pole, etc.)5/11/25 - (R2) is to have non-skid footwear on while in bed.7/11/25 - non-skid socks on while in bed.8/10/25 - Dycem placed in wheelchair.R2's F/U Occurrence Note dated 8/17/25 at 7:15 AM documents Incident Note: unwitnessed fall. CNA (Certified Nursing Aid) found (R2) on the floor @715. (R2) states she was not standing she was washing her face and tried to put her face towel on the dresser, but the wheelchair slid from under. I did a full head to toe assessment on (R2) with ROM (Range of Motion). She hit the right side of head and blood was on her hand, floor and towel. Denies any pain. V/S (Vital sign) (blood pressure) 115/75 P. (pulse)85 R. (respirations) 18 temp.(temperature) 97.6 O2. (oxygen saturations) 96%. Pt. (patient) A&O (alert and oriented) X 2. transferred to bed with two nurses and two CNA. pt stable. called 911. contacted POA. @740. Ambulance arrived @750. Contacted MD @751. Contacted DON (Director of Nursing) @ 752 left VM (voicemail).No care plan intervention noted for this fall.Facility Fall Investigation dated 8/17/25 at 7:15 AM documents fall, resident room, sitting. Fall caused by patient intent or behavior. Laying on ground. Resident just got up out of bed and was sitting the wheelchair. Assessment/Documentation, Fall Assessment Completed, Neuro checks initiated, routine safety checks, notified immediate supervisor, first aid initiated, Do not move, call bell in reach with instruction. Resident was sent to ED (Emergency Department) for further evaluation. Problem Statement: Resident attempting to get out of wheelchair. Root Cause: Resident attempting to get out of wheelchair. Investigative Statements: Nurse: unwitnessed fall. CNA found (R2) on the floor @ 7:15. (R2) states, she was not standing she was washing her face and tried to put her face towel on the dresser but the wheelchair slid from under. I did a full head to toe assessment on [NAME] with ROM. She hit the right side of head and blood was on her hand, floor, and towel. Denies any pain. V/S 115/75 R 18 temp. 97.6 O2. 96% Pt. A&O X 2. Transferred to bed with two nurse and two CNA. Pt stable. Called 911. Resident: Resident stated she wasn't trying to get out of bed and walk, she was reaching over to put something away.R2's Health Status note dated 1/14/26 at 2:13 PM documents res (resident) leaning forward in w/c and fell forward out of chair, hit head on leg of STS (Sit to Stand), MD here and states to send to ER for Eval (Evaluation).No care plan intervention noted for this fall. Facility's Fall Investigation dated 1/14/26 at 3:00 PM documents Fall, resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, sitting. Fall caused by patient intent or behavior. Resident went from chair to floor. No injuries noted. Assessment/Documentation, Fall Assessment completed, neuro checks initiated, notified immediate supervisor. Resident witnessed hit head and sent to ED per MD for further evaluation, education to staff to lay resident down immediately after meals. Problem Statement: Resident is A&O x 2, poor safety awareness, BIMS 9, intention of getting out of the w/c. Root Cause: Resident is A&O x 2, poor safety awareness, BIMS 9, intention of getting out of the w/c so she could get to bed. Investigative Statements: Nurse: res leaning forward in w/c and fell forward out of chair, hit head on leg of STS, MD here and states to send to ER for eval. Resident: resident stated she fell and that she wanted out of her chair. Witness: This nurse was walking past room and witnessed resident scooting to edge of wheelchair and pushed self out of chair and fell to floor hitting head on based of sit to stand. Resident was assessed and stated her head hurt. Floor nurse notified POA and MD. Resident to be sent to ED for further evaluation.#2.R5's EMR undated documents that the resident was admitted to the facility on [DATE].R5's EMR dated 8/22/25 documents a diagnosis of Parkinson's Disease without Dyskinesia, without mention of fluctuations, encounter for palliative care, and Malignant Neoplasm of Unspecified Renal Pelvis.R5's MDS dated [DATE] documents a BIMS score of 12 out of 15. The MDS documents that the resident is dependent for roll left and right, sit to lying, chair/bed to chair transfer, and tub/shower transfer. The MDS documents that the resident has an indwelling catheter.R5's Care Plan dated 8/26/25 documents [NAME] is at risk for falls and injuries r/t side effects of his psychotropic and opioid medication use. He is also at risk due to his diagnosis of Parkinson's disease and his involuntary movements. [NAME] has a history of falls. Due to his involuntary movements, [NAME] has been noted to slide out of bed. He currently has a low bed and double mattresses.Interventions:8/25/25 - bed in lowest position.8/25/25 - Encourage call light usage.8/25/25 - floor mat at bedside when in bed.8/25/25 - keep environment free from clutter.8/25/25 - Keep personal belongings within reach.8/25/25 - provide adequate lighting.10/23/25 - bolster on mattress. Hospice provided.11/10/25 - personal alarm on resident.R5's Health Status note dated 9/17/25 at 12:43 AM documents UPON MIDNIGHT Rounding Resident noted in his room, laying on the bathroom floor, on his Right side. Upon assessment (indwelling) Cath detached from Resident's Penis, a large amount of blood noted on the floor, and penis. Resident states he doesn't know where he was going or what he was trying to do at the time of Fall. Resident denies hitting his head. Resident states he is not so much in pain Resident's Bed was still in the lowest position and safety mat was in place. Resident was Mechanical lifted from the floor to his Bed. V/S: BP 128/82 HR 97 t 97.4F R 20 PERRLA (Pupils Equal Round Reactive to Light Accommodation), RESIDENT was a&o X2-3. 911 was called at 12:03AM, RES WIFE AND DAUGHTER NOTIFIED AT 12:04AM, MD NOTIFIED AT 12:05AM,EMS ARRIVED AT 12:15 AND RESIDENT WAS TRANSPORTED TO (Regional Hospital) AROUND 12:20AM.No care plan intervention noted for this fall.Facility's Fall Investigation dated 9/17/25 at 12:43 AM documents Found on floor. Laying on bathroom floor. No injuries noted. Assessment/Documentation. Care Plan updated. Neuro checks initiated. Notified immediate supervisor. Sent out for further evaluation, resident noted confusion with uti (Urinary tract Infection) on abt (Antibiotic). Problem Statement: Resident confused with poor safety awareness, and attempting to get out of bed without assistance. Root Cause: Resident confused, with poor safety awareness, and attempting to get out of bed without assistance. Investigative Statements: Nurse: Upon Midnight rounding Resident noted in his room, laying on the bathroom floor, on his right side. Upon assessment Foley Cath. Detached from Resident's penis, a large amount of blood noted on the floor, and penis. Resident states he doesn't know where he was going or what he was trying to do at the time of fall. Resident denies hitting his head. Resident states he is not so much in pain. Resident's bed was still in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lowest position and safety mat was in place. Resident was mechanical lifted from the floor to his bed. V/S: BP 128/82 HR 97 t 97.4F R 20 PERRLA, Resident was a&o x 2-3. 911 called at 12:03AM, Res. wife and daughter([NAME]) notified at 12:04AM, MD notified at 12:05AM, EMS arrived at 12:15 and resident was transported to (Regional Hospital)12:20am.R5's F/U Occurrence Note dated 12/30/25 at 2:00 AM documents Incident Note: Observed lying on floor next to bed and window, on floor mat lying on stomach with arms at side and legs extended. Slow response made eye contact but no verbal response. Moving extremities, no shortening or rotation of legs noted. Transferred from floor to bed via full mechanical lift and 3 assist. More responsive but slow, mumbling speech. Small red area to left cheek bone. Neuro checks initiated. (Indwelling) catheter patent draining dark yellow urine. Call light within reach. Hospice care.No care plan intervention noted for this fall.Facility's Fall Investigation dated 12/30/25 at 2:00 AM documents Fall, Resident room, in bed. Found on floor. On floor mat on stomach. No injuries noted.On 1/23/26 at 3:00 PM, V2, DON stated that some of the falls happened before she was hired. She stated that Care Plan Coordinator is new and learning.Facility's Accidents & Incidents policy dated 7/1/23 documents To provide staff with guidelines for investigating, reporting, and recording Accidents and Incidents. 4. Investigated and Follow up Action: A. The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties. E. The D.O.N, IDT (Interdisciplinary Team), and /or Designee will conduct an investigation of the accident/incident as well. Findings will be indicated in the appropriate area. The IDT will review within 24 hour or next business day and discuss and attempt to find out root cause and implement an appropriate intervention to attempt to prevent further falls.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on interview, observation, and record review the facility failed to provide residents with a working call light system for 22 (R2, R4, R6 - R25) out of 23 residents investigated for physical environment in a sample of 25.Findings include:On 1/20/26 at 10:06 AM, R4 stated that her call light does not work, and the bathroom call light does not work. She stated that the bell that the facility gave her no body hears it. She stated that other resident's call lights do not work either. She stated that this has been going on for 4 months. She stated that they tried to fix it, but it's still broken.On 1/21/26 at 9:01 AM, R6 stated that her call light does not work. She stated that she cannot find her bell.On 1/21/26 at 12:24 PM, V5, Maintenance Supervisor stated that the whole call light system is getting replaced. He stated that the contractor is scheduled about 2 weeks away.On 1/21/26 at 12:27 PM, V1, Administrator stated that it's about 2 weeks until the new call light system is installed. He stated that they cannot get parts for the old system, so the facility has to replace the whole system.Facility's Grievance Form dated 11/4/25 documents Resident's daughter-in-law was upset about the call light system being down.Facility's Call Light Testing Log dated 11/26/25 documents that 22 residents call lights failed during testing.On 1/20/26 at 10:06 AM, observation of R4 had a tabletop bell sitting on her dresser.On 1/21/26 at 9:01 AM, No bell noted on R6's bedside table or dresser.On 1/21/26 at 3:07 PM, observation of tabletop bell sitting on R2's bedside table next to bed.Facility's Call Light Guidance Policy dated 7/1/23 documents 1. When initiated, the system will light up in the room, outside the room and on a central panel.