

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Staunton Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a call light was in reach and residents had a means to call for help for 1 of 3 (R11) residents reviewed for accommodation of needs in a sample of 31. This failure resulted in R11 unable to receive help. It also resulted in R11 feeling frightened, frustrated, embarrassed, helpless and disposed of. Findings include: 1. R11's admission Record, not dated, documents that R11 was admitted on [DATE] with diagnosis of Multiple Sclerosis and Quadriplegia. R11's Care Plan, dated 7/1/2025, (R11) has Quadriplegia. He requires assist with all of his ADL's (Activities of daily living). It also documents 8/4/2025 (R11) have Multiple Sclerosis. He is dependent on all ADLs. He is at increased risk for his needs not being met. R11's Minimum Data Set, dated [DATE], documents that R11 is cognitively intact and dependent on staff for all adls. On 5/26/26 at 10:20 AM, R11 observed lying in bed turned to his left side with a blow call light in front of his mouth. R11 attempted to reach the blow stem with his lips but was too far - used his tongue to move it closer to him and then was able to blow into the device to turn on his call light. On 5/26/26 at 10:20 AM R11 stated he uses it (call light) but sometimes they put it too far away like it is this morning. On 5/27/26 at 2:02 PM, R11 was heard yelling for help in his room. R11's was observed lying flat in his bed. When asked how long he had been lying flat, R11 stated Probably about 15 minutes now. They were going to get me up to my wheelchair for my doctors appointment, they laid me flat but left the room. I was starting to taste my feeding, and it scared me, that's why I was yelling. R11's call light was moved away from his mouth and was unable to use it. On 5/27/2026 at 9:15 AM R11 stated that he is not sure of the date, but he did have a change in condition and required hospitalization. R11 stated that he thought it was a stroke but found out it was shingles. R11 stated that it is multiple times that his call light is not in reach. R11 stated that he is paralyzed from the neck down. R11 stated that he can only move his head. R11 stated that he has a blow call light. R11 stated that it is activated by him blowing in it. R11 stated that there are times that his call light is not in reach. R11 stated that he must yell for help and because he doesn't have a lot of air movement his voice is low toned. R11 stated that the staff do not hear him for hours at a time. R11 stated that it's frightening because he has no way to get help if he needs it. R11 stated that he feels helpless and disposed of. R11 stated that he is aware of his limitations and tries to stay as positive as he can but it's frustrating, embarrassing and he feels helpless. On 5/28/2026 at 9:00 AM V1, Administrator, stated that R11 is quadriplegic and requires the use of the blow call light to alert staff of his needs. V1 stated that the call light needs to always be in place. V1 stated that R11 has a low voice, and it would be difficult to hear him. V1 stated that she always expects R11's call light to be in his reach. On 5/28/26 at 11:20 AM, R11 stated It scared me yesterday. I can hardly talk with my voice so soft, but all I could do was try to yell and get someone's attention because they left me lying flat and I was starting to taste my feeding. It really scared me. When they keep my blow call light out of reach, I get scared because I cannot get anybody if I need help. On 6/1/2026 at V13, Licensed Practical Nurse, stated that R11's call light is to be in reach. On 6/1/26 at 10:25 AM, V18, CNA, stated (R11) has his mouth call light and he will tell us when it is placed correctly. He has to be able to reach it with his mouth. The facility's Call Light Guidance policy, dated 7/1/2023, documents that PURPOSE: To provide guidance (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145286	If continuation sheet Page 1 of 6

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F 0558 Level of Harm - Actual harm Residents Affected - Few	to all facility staff on the use, response and placement of call lights. PROCEDURE: 2. A call light activation device shall be kept within resident reach while in resident rooms and bathrooms.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to identify, treat, and prevent pressure ulcers for 3 of 5 residents (R4, R9, R13) reviewed for pressure ulcers in the sample of 31. This failure resulted in R4 and R13 having new pressure sores that were not discovered or treated. The findings include:1. R4's admission Record, dated 5/28/26, documents R4 was admitted to the facility on [DATE]. R4's Electronic Medical Record, under Medical Diagnosis, documents R4's diagnosis dated 4/6/26: Periprosthetic fracture around internal prosthetic right hip joint, displaced subtrochanteric fracture of right femur, displaced fracture of lesser trochanter of right femur. On 4/14/26 new diagnosis of wedge compression fracture of third lumbar vertebra, wedge fracture of fourth lumbar vertebra, wedge compression fracture of T7-T8 vertebra, history of falls, Asthma, Chronic Kidney Disease, Atherosclerosis, Urinary Tract Infections, Malnutrition, Osteoarthritis, Benign Prostatic Hyperplasia, Malignant neoplasm of prostate, Anemia, Hypertension, Atrial Fibrillation. R4's Care Plan, dated 5/23/26, documents R4 has a Potential for impaired skin integrity. Interventions: Assist/provide peri-care after each incontinence episode, encourage and assist to turn and reposition routinely and per resident's request, evaluate skin at least weekly, observe skin integrity during am/pm cares, pressure redistribution cushion-wheelchair, pressure redistribution mattress to bed, reposition at least every two hours in bed. R4's Minimum Data Set (MDS), dated [DATE], documents R4 has a moderate cognitive impairment and is dependent on staff for all activities of daily living (ADLs) and transfers. R4 is always incontinent of both bowel and bladder. R4's Physician Order (PO), dated 5/26/26, documents Barrier Cream to buttock r/t (related to) incontinence as needed for when incontinent. R4's PO, dated 5/11/26, documents Cleanse left heel with NS (normal saline)/WC (wound cleanser). Apply skin prep and leave OTA (open to air) every day and night shift for wound healing and as needed for wound healing. R4's PO, dated 4/20/26, documents Daily Skin Check Using the following C-clear R-Red O-open p-Pressure S-skin tear every day shift. R4's PO, dated 4/14/26, documents Refer to Wound Care for consult as needed. R4's PO, dated 4/14/26, documents Moisture barrier cream as a preventative every shift for preventative. R4's PO, dated 4/14/26, documents Skin Inspection / Nursing Weekly Assessment on Saturdays one time a day every Sat. On 5/26/26 at 9:40 AM, R4 seen sitting in his wheelchair with a soft boot on his left foot with an obvious pressure wound seen on his heel and no dressing on, and another pressure sore noted to the lateral right foot, also without a dressing on. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/26/26 at 10:40 AM, V9, Certified Nursing Assistant (CNA), and V11, CNA, entered with supplies to provide incontinent care to R4. During incontinent care, there was a small open area noticed on R4's left buttock that does not appear to have been treated and neither CNA was aware of it being there before. R4's Health Status Note, dated 5/26/26 at 12:02 PM, documents Resident noted to have small, macerated area to inner left buttock. MD (medical doctor) aware with new orders to apply barrier. POA (Power of Attorney) and wound nurse aware. On 5/27/26 at 11:20 AM, V7, Wound Nurse, stated (R4) does have a new wound to his left buttock that he did not have before. On 5/27/26 at 2:06 PM, V7, Wound Care Nurse, and V18, CNA, entered to do wound care on R4. R4 was seen lying on his left side with a soft boot on his right foot. V7 stated (R4) always has one on his left foot and I'm not sure why he would have one on his right foot. Upon removing the soft boot, there was a quarter sized wound on his lateral foot. V7 stated I know nothing about that wound. No one has mentioned it to me. I would call this wound a pressure sore that is unstageable at this point. Upon looking at R4's right heel, there appears to be another sore on his medial heel that was a dark/blackened area also about a quarter size. V7 stated No one mentioned that one to me either. We had issues with this before and we did skin sweeps with our last one done in April and (R4) did not have these wounds, he only had the one on his left heel. When asked about R4's new wound to his right buttock, V7 stated That is also a new wound that was not reported to me until yesterday when you found it. We are just putting Triad paste on it for now. On 5/27/26 at 2:22 PM, V7 stated Whoever finds a new wound should be reporting it to the nurse and that nurse will report it to me. I was not told (R4) had any wounds except for his left heel. On 6/1/26 at 10:25 AM, V18, CNA, stated Any new wounds or skin issue should be written on the shower sheets when we give them a bath or shower. It should also be reported to the nurse. I report things even if they are old wounds, just to make sure. R4's Shower Sheets for the month of May 2026, documents R4's wounds as left heel open sore, and right hip surgical wound only with no mention of R4's right lateral foot, right heel, or wound to his buttock. On 6/1/26 at 8:45 AM, V30, Nurse Practitioner (NP), stated I expect any staff who find redness or a new wound to report that area to the wound nurse, who will then report it to me. We do skin sweeps every three months and look at every resident's skin and assess for redness and/or new wounds. (R4) went from one wound to five wounds because no one notified the wound nurse or me. There is a big communication problem here with reporting of skin issues. (V7, wound nurse) is a great wound care nurse but if no one tells her about a new wound, she is not able to let me know and to take care of that wound. It's sad that (R4) had to get to this, but I will get his wounds healed. On 6/1/26 at 10:05 AM, V1, Administrator, stated I would expect all staff who are caring for the residents to identify any new skin issues or wounds, notify the nurses and/or physician, to get proper physician orders, then to treat those wounds appropriately as ordered. 2. R13's Care Plan, dated 5/27/2026, documents that documents that R13 has Pressure Ulcer to sacrum. Requires assist with turning and repositioning. 4/28/26 Potential for impaired skin integrity (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	related to: decreased mobility, incontinence, and poor nutritional intake. R13's Braden Scale, dated 5/19/26, documents that R13 is at high risk for pressure ulcers. R13's Health Status Note, 5/26/2026 at 2:52 PM, documents Note Text: While changing dressing, resident noted to have small, reddened area to sacrum. Apply barrier cream BID (twice daily) and PRN (as needed). MD (doctor) faxed. On 5/26/2026 at 9:46 AM observed V7 performing wound care for R13. During treatment observed a small red and open area to R13's coccyx. No treatment was performed. On 5/26/2026 at 9:46 AM V7 stated that the wound was open and new. 3.R9's Facesheet with a print date of 5/28/26 documented she was admitted to the facility on [DATE] with diagnosis of, in part, pressure ulcer of left buttock stage four, type two diabetes mellitus, and surgical aftercare following surgery on the skin and subcutaneous tissue. R9's MDS dated [DATE] documented she was cognitively intact and dependent on staff for all mobility tasks. R9's Care Plan dated 4/17/26 documented R9 has the potential for impaired skin integrity related to decreased mobility, and a current pressure ulcer to left buttock. R9's Care Plan dated 5/12/26 documented R9 had actual pressure ulcer; left buttock, stage four with an intervention for staff to check dressing placement every shift. R9's May 2026 Treatment Administration Record documented orders as follow: cleanse left buttock with wound cleanser or NS (normal saline), apply wet-to-dry dressing to wound bed ensuring to pack undermining, cover with dry dressing. change daily and (as needed) PRN every day shift every 3 day(s) for wound care -Start Date- 05/21/2026 0600 (6:00 AM) and cleanse right hip with NS or wound cleanser and pat dry, cover wound with bordered foam dressing. Change 3x (times) weekly 1x per hospice nurse and 2x per facility nurse. staff nurse may change prn. every day shift every 3 day(s) for wound care. -Start Date- 05/21/2026 0600. R9's Hospice Order Sheet dated 5/20/26 documented orders for stage two pressure ulcer to be changed three times weekly, 1 time per hospice nurse, two times weekly for facility staff nurse; may change if dressing becomes soiled or displaced. The hospice order sheet continued to document orders for R9's stage four pressure ulcer to be changed three times weekly, 1 time per hospice nurse, two times weekly for facility staff nurse; may change if dressing becomes soiled or displaced. On 5/27/26 at 12:21 PM, V19 (Hospice RN) and V20 (Hospice RN) went in to provide wound care for R9. V20 stated R9's left buttock pressure wound did not have a dressing in place and said she was told they recently provided peri care for her. V20 and V19 rolled R9 onto her left side. R9's right hip had an old dressing in place dated 5/23/26 with a moderate amount of drainage covered on a bordered gauze dressing. V20 stated the old dressing was dated 5/23/26 and the facility is supposed to be completing the wound care orders on days we are not here. V20 and V19 stated the orders are for the facility to be completing it two times a week and hospice will do one day while they can also change as needed. On 5/28/26 at 8:08 AM, V7 (Wound Nurse/IP) stated hospice told her last week they wanted R9's (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound care to be Monday, Wednesday, Fridays; the nurse that entered her orders placed it to be done every three days and that would not amount to three times a week. V7 stated she expects staff to be following the orders as written and will have to correct R9's orders right away. The facility's Pressure Ulcer Prevention, Identification and Treatment policy dated 10/16/23 documented. It is the responsibility of the. Charge Nurse/Designee to care for pressure areas, and provide treatments as ordered. It is the responsibility of the Charge Nurse/Designee to measure and document on the pressure areas weekly. It is the responsibility of the Charge Nurse/Designee to monitor for healing progress, and ensure appropriate treatment are in use. It is recommended that D.O.N./Designee make frequent pressure ulcer rounds with the charge nurse. It is the responsibility of the CNA to report any skin conditions to the charge nurse immediately upon identification.		